Health and welfare services in
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HEALTH AND WELFARE SERVICES

IN CANADA

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HEALTH AND WELFARE SERVICES IN CANADA

Research and Statistics Directorate

Honourable Allan J. MacEachen
Minister of National Health and Welfare

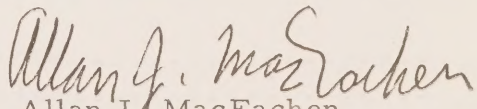
John N. Crawford, M.D.,
Deputy Minister of National Health

Joseph W. Willard,
Deputy Minister of National Welfare

FOREWORD

This booklet contains the material prepared by the Research and Statistics Directorate for inclusion in the chapter, "Public Health, Welfare, and Social Security" of the Canada Year Book. Additionally, certain material is included here which was omitted from that chapter in the interests of brevity. Sections contributed to the Canada Year Book chapter by other agencies are of course not included in this booklet.

The Research and Statistics Directorate is indebted to several Departmental officers for contributing various sections of the booklet. Many other sections were prepared by the staff of the Directorate. Editing was by Mr. Arthur F. Smith, under the general direction of Mr. William A. Mennie, Acting Director, Research and Statistics.



Allan J. MacEachen
Minister
National Health and Welfare

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INTRODUCTION

Several important developments in health and social welfare took place in Canada during 1966-1967.

The first Canadian Conference on Aging, sponsored by the Canadian Welfare Council in Toronto in January 1966, sought ways and means of improving the life of older people. Delegates represented labour, management, professional organizations, voluntary organizations and the churches. The report of the Special Committee of the Senate on Aging, released in February 1966, recommended a guaranteed income for older people, improvements in housing, health and institutional care, social services, community participation, recreation programs, and the establishment of a national commission on aging.

An amendment to the federal Old Age Security Act, effective January 1, 1967, provides guaranteed income supplements to recipients of Old Age Security who have little or no other income. The maximum amount of the supplement was initially $30 per month (see p. 60)

The Act to establish the Canada Pension Plan (SC 1964-65, c.51), which became operational on January 1, 1966, established for the first time in Canada a comprehensive social insurance program of contributory, old age, disability and survivors' pensions. The Act provides an earnings-related old age pension and adjusts the existing tax-financed flat-rate old age security pension so that the two pensions form an integrated system. It also provides supplementary pensions and lump-sum benefits for disabled contributors and their dependent children, and for survivors of contributors (see p.52).

The enactment of the Canada and Quebec Pension Plans emphasized the need for uniform private pension legislation across Canada. Ontario amended the Ontario Pension Benefits Act with effect from July 30, 1965, and Quebec enacted the Supplemental Pension Plans Act with effect from July 15, 1965. The pension benefits act of Alberta came into force on January 1, 1967, and that of Saskatchewan was assented to on April 1, 1967. The Pension Benefits Standards Act of Canada, relating to persons employed in works, undertakings, and businesses (generally, banks and interprovincial transportation and communication) that are under federal jurisdiction, was assented to on March 23, 1967. All these Acts regulate private pension plans, ensure portability and solvency of the private plans, and require the provision of information to the members of the plan.

An amendment to the federal Agricultural Rehabilitation and Development Act (ARDA), assented to on May 12, 1966, renamed it the Agricultural and Rural Development Act and widened its scope correspondingly. This Act has important implications for welfare, in that its goals include "the development of income and employment opportunities" and "the improvement of standards of living". Related to ARDA is the Fund for Rural Economic Development Act, assented to on July 11, 1966, which provides funds for projects designed to develop particular areas and established in agreements with the provinces. The amount of the Fund, originally $50,000,000, was increased to $300,000,000 by an amendment assented to on March 10, 1967.

The Canada Assistance Plan, which was given Royal Assent on July 15, 1966, provides for a comprehensive welfare system to replace the programs for specific categories, such as old age assistance, blind and disabled persons' allowances, and unemployment assistance; extends existing social assistance and welfare coverage; and substitutes a needs test for a test of means as a qualification for assistance. Provincial programs for persons in need, including health care services, will be supported by federal-provincial cost-sharing arrangements (see p. 69).

The federal Medical Care Act, which provides for the setting up of a comprehensive medical care insurance program, was assented to on December 21, 1966, and is to come into effect not later than July 1,1968. On September 1, 1965 the British Columbia Medical Plan took effect. On July 1, 1966 the Ontario Medical Services Insurance Plan, and on July 1, 1965, the Alberta Health Plan (an extension of the former Alberta Medical Plan), began paying benefits. These three provincial plans are voluntary and provide for subsidization of premiums for low income groups (see pages 14 and 40).

The Health Resources Fund Act was given Royal Assent on July 11, 1966. It provides $500,000,000 over the fifteen-year period 1966-1980 to assist provinces in the acquisition, construction, and renovation of health training facilities and research institutions (see p. 16).

PART I - PUBLIC HEALTH

Provincial governments bear the major responsibility for health services in Canada, with the municipality often assuming considerable authority over matters delegated to it by provincial legislation. The Government of Canada has jurisdiction over a number of health matters of a national character and provides important financial assistance to provincial health and hospital services. All levels of government are aided and supported by a network of voluntary agencies working in different health fields.

Section 1 - Federal Health Activities

The Department of National Health and Welfare is the chief federal agency in health matters but important treatment programs are also administered by the Departments of Veterans Affairs and National Defence. The Dominion Bureau of Statistics is responsible for collection, analysis, and publication of national health statistics, the Medical Research Council and the Defence Research Board administer medical research programs, and the Department of Agriculture has certain health responsibilities connected with food production.

The Department of National Health and Welfare is concerned with food and drugs, including narcotics, operates quarantine and immigration medical services, carries out international health obligations, and provides health services to Indians, Eskimos, and other special groups. It advises on medical aspects of eligibility of applicants for blindness allowances and co-operates with the provinces in the provision of surgical or remedial treatment for recipients of the allowances. Under the Public Works Health Act, supervision of health conditions is provided for persons employed on federal public works. Health counselling and medical supervision are provided for the federal Public Service. The Department also administers the civil aviation medical program for the Department of Transport.

Subsection 1 - Food and Drug Control

The provisions of the Food and Drugs Act, administered by the Food and Drug Directorate of the Department of National Health and Welfare, apply to the manufacture, advertising, packaging, and sale of foods, drugs, cosmetics, and medical devices anywhere in Canada. Wide powers are given under this legislation to maintain the safety, purity, and quality of food and drug products and to prevent misrepresentation in labelling and advertising. There are prohibitions, for example, on the sale of food or drugs that do not meet prescribed standards, are harmful, adulterated, dirty, improperly stored, or manufactured under unsanitary conditions. The Act also prohibits the advertising of any food, drug, cosmetic, or medical device as a preventive or cure for a number of serious diseases and also lists drugs that may be sold only by prescription.

Standards of safety and purity are maintained through constant and widespread inspection and laboratory research. The inspection of food-manufacturing establishments plays a major role in the production of clean, wholesome foods containing ingredients that meet recognized standards. Changing food technology requires the development of methods of laboratory analysis to ensure the safety of new types of ingredients and packaging materials. The Food and Drug Regulations list chemical additives that may be used in foods, the amounts that may be added to each food, and the underlying reason. Considerable emphasis is placed upon studies to ensure that the levels of pesticide residues in foods do not constitute a health hazard. The effect of new packaging and processing techniques on the bacteria associated with food spoilage is also of special concern. Since the Act is intended for the protection of consumers, a section of the Directorate obtains consumer opinions, deals with individual consumer complaints, and provides information on which consumers can base opinions.

Drug standards are subject to continuous review and testing. Detailed information on all new drugs must be reviewed by the Directorate to determine compliance with re-

quirements before release for sale is permitted. Drug regulations set standards for drug manufacturing, facilities and controls, and prescribe additional safeguards in the distribution of investigational and new drugs. Drug manufacturing requirements relate to sanitation of facilities, employment of qualified personnel, testing to ensure standards of quality and safety at stated stages of processing, maintenance of records on testing performance, together with a system of control to enable a complete and rapid recall of any lot or batch of drugs from the market. The controls over clinical trials and marketing of new drugs require detailed information to be submitted to the Directorate concerning the method of manufacture, the tests applied to establish standards of safety and quality, and substantial evidence of the clinical effectiveness of the new drug for the purposes stated. Samples of the final product must also be submitted. Before carrying out clinical trials, a manufacturer also must file complete data on his experience with the drug including any evidence of adverse side effects, and the qualifications of the persons to be engaged in its investigational use. The Minister may suspend clinical testing based on this evidence if he feels that it is in the public interest to do so; in such case the manufacturer has the right to appeal the decision. Drugs expressly prohibited from sale are thalidomide and lysergic acid diethylamide, except under certain conditions as specified in the regulations, whereby sale by a manufacturer to an institution for clinical use or laboratory research by qualified investigators may be approved by the Minister. Any drug that can be classed as a sedative, hypnotic, or tranquillizer is listed to be sold only on prescription. The licensing of persons dealing in certain drugs classed as barbiturates and amphetamines is required as well as the keeping of special records and the limitation of their use to medical purposes.

The Food and Drug Directorate administers the Proprietary or Patent Medicine Act, which is concerned with the voluntary registration before marketing and the annual licensing of secret-formula medicines sold under proprietary or trade names.

Since 1965 the Directorate has conducted an adverse-drug-reaction reporting program in teaching hospitals across Canada to recognize and investigate reactions to drugs. The co-operation of the medical, dental, veterinary, and pharma-

ceutical professions was solicited in advising the Directorate of such reactions in private practice. Close liaison is maintained with the World Health Organization and other authorities in foreign countries for the prompt reporting of such reactions.

Since October 1966, every manufacturer and distributor of drugs in Canada (products registered under the Proprietary or Patent Medicine Act exempt) is required to submit to the Food and Drug Directorate certain information on all products he is marketing in Canada and each time he intends to market another product, make changes in existing products, or withdraw a product from the market, he must notify the Directorate.

Regulation of the supply and use of narcotic drugs is carried out under the Narcotic Control Act, as revised in 1961. This legislation prescribes a maximum penalty of seven years for illegal possession; a maximum penalty of life imprisonment for trafficking; and penalties from seven years to life imprisonment for illegal export and import. The Royal Canadian Mounted Police and other law enforcement agencies continue to make every effort to keep the illicit traffic to a minimum.

Subsection 2 - Medical Services

Through its Medical Services Branch, the Department of National Health and Welfare provides several direct and indirect types of medical service, as described in the following paragraphs. "Indirect" services are provided by hiring local services where practicable.

Indians and Eskimos. - Medical and public health services are made available to registered Indians or Eskimos who are not included under provincial arrangements and who are unable to provide for themselves. A large volume of the service in treatment and health education is rendered to patients through 83 departmental out-patient clinics staffed by medical and other public health personnel. In remote areas, the key facility is frequently the departmental nursing station, a combined emergency treatment and public health unit having two to four beds under the direction of one or two nurses; 46 of these are operated throughout Canada.

Where practicable, there has been an increasing integration of Indians into provincial and municipal health agencies and the number of hospitals and other facilities provided specifically for them have been reduced accordingly.

At present the Department maintains 15 hospitals at strategic points and co-operates with community, mission, or company hospitals. Indians are now included under all provincial prepaid insurance plans for hospital care and other forms of insured medical care but in almost all cases the cost of mental and tuberculosis care is borne directly by the federal government. Indian and Eskimo health workers are trained to give instruction in health care and sanitation.

Northern health. - Because of the special problems in developing health services in the Far North, the Department of National Health and Welfare has been given the responsibility of co-ordinating federal and territorial health care for all residents. In so doing, it undertakes the functions of a health department for the Council of the Northwest Territories and assists the territorial government of the Yukon Territory to provide certain health services. A close liaison is maintained with the federal departments directly responsible for administrative matters affecting these areas. Hospital insurance plans are in effect in both territories.

In the Yukon Territory, services for the total population administered through the Commissioner for the Yukon and provided on a cost-sharing basis with the Department of National Health and Welfare include complete treatment for tuberculosis, payment for services rendered at the Alberta cancer clinics, mental hospital care through arrangements with the Province of British Columbia, and medical care for indigent patients. Public health nursing services, measures for control of communicable diseases, and administration of the principal public hospital are primarily the responsibility of the Department.

Similar services are provided in the Northwest Territories. The costs of these services are shared between the respective territorial government and the Departments of National Health and Welfare and of Indian Affairs and Northern Development.

Sick mariners. - The Department provides compulsorily insured medical, surgical, hospital, and other treatment services to crew members of all foreign-going ships arriving in Canada and Canadian coastal vessels in interprovincial trade, and provides medical, surgical, and treatment insurance on an elective basis to crew members of Canadian fishing and government vessels. (Canadian seamen obtain their hospital care under the provincial hospital insurance plans.)

Quarantine. - Under the Quarantine Act, all vessels, aircraft, and other conveyances and their crew and passengers arriving in Canada from foreign countries are inspected by the quarantine officers to detect and correct conditions that could lead to the entry into Canada of such diseases as smallpox, cholera, plague, yellow fever, typhus, and relapsing fever. Fully organized quarantine stations are located at all major seaports and airports.

Immigration. - Under the Immigration Act and the Department of National Health and Welfare Act, the Immigration Medical Service conducts in Canada and other countries the medical examination of all applicants for immigration to Canada and also provides treatment for certain classes of persons after arrival in Canada, including immigrants who become ill en route to their destination or while awaiting employment.

Public service health counselling. - Health counselling is offered through Medical Services units to federal employees throughout the country. This service is primarily diagnostic and advisory only, but emergency treatment can also be given.

Civil aviation medical inspection service. - Airpilots and other air personnel are routinely examined for physical and mental fitness for the performance of their duties.

Regulation of hygienic standards. - The Department is responsible for regulating hygienic standards on federal property, interprovincial common carriers, Canadian shipping and aircraft.

Coast Guard medical service. - The Department provides a medical service for and in conjunction with the Canadian Coast Guard.

Subsection 3 - Health Research

Health research in Canada is carried on in universities, hospitals, research institutions, and government departments. The main sources of financial support are governments, voluntary agencies, charitable foundations, professional bodies, and business corporations. In 1962 health research funds amounted to approximately $10 million; by 1966 they had climbed to more than $20 million.

The federal government conducts intramural medical and dental research within the Department of National Health and Welfare, the Defence Research Board and the Department of Veterans Affairs. The Medical Research Council, the National Research Council, the Department of National Health and Welfare, the Department of National Defence, the Department of Veterans Affairs, the Queen Elizabeth II Fund, and the Smoking and Health Program of the Department of National Health and Welfare have given financial support to extramural research in universities, hospitals and other institutions.

The Medical Research Council, since its formation in 1960, has become the principal federal agency for all medical research except those specialized areas assigned to other agencies including public health, defence, and veterans. Primary attention has been given to fundamental research in the basic medical sciences but clinical research is also supported. The Medical Research Council administers most of the federal medical research grants that support full-time investigation by research scientists in Canadian medical schools and their affiliated hospitals. The National Research Council pursues in its broad program many investigations relevant to health. Its Associate Committee on Dental Research administers specific grants for dental research and for training dental-research personnel.

Health research on prevention of disease, epidemiology, environmental health, and operation is supported by the Department of National Health and Welfare. Intramural research is conducted by the Food and Drug Directorate, the Medical Services Branch, the Health Insurance and Resources Branch, by several divisions and laboratories of the Health Services Branch and by the Research and Statistics Directorate.

The Department's extramural research includes projects relating to smoking and health, public health research, surveys, and studies, that have been approved by the province prior to receiving assistance under the National Health Grants Program.

The Defence Research Board sponsors both intramural and extramural research on medical problems of defence interest and supports a special unit to conduct research in aviation medicine established at McGill University. The Department of Veterans Affairs maintains a program of medical and dental research in its clinics across Canada dealing mainly with conditions related to aging.

The Queen Elizabeth II Fund for Research in the Diseases of Children, established by the federal government in 1959, annually makes a fixed sum available for training researchers and scientists in children's diseases.

The Smoking and Health Research Program was initiated in 1963 as part of an educational and research program on the health hazards of cigarette smoking.

Subsection 4 - Radiation Protection

A comprehensive radiation protection program has been developed in Canada in response to the rapidly increasing use of radioactive materials, X-ray equipment, and nuclear reactors in medicine, industry, and research, and to the increasing concern about radiation from atmospheric testing of nuclear weapons, from medical X-ray procedures, and from natural sources.

Because of the need for national controls over uranium and radioactive by-products, the federal government has developed procedures for the safe handling and use of all radioactive materials. These are implemented through special advisory committees with close collaboration of federal and provincial health departments. Acting as the principal health advisor under the Atomic Energy Control Regulations, the Department of National Health and Welfare reviews all applications for radioisotope licenses and recommends health and safety conditions.

Members of the Department serve on special advisory committees to the Atomic Energy Control Board to review the siting, design, construction and operation of nuclear reactors and charged-particle accelerators and to make recommendations. Although there is no federal regulatory authority to provide health and safety supervision over the use of X-rays, the Department has established a committee on the development of X-ray safety standards to prepare and recommend uniform standards and procedures throughout Canada. The committee has recommended that the sale of such equipment be subject to federal control and its installation to provincial control. Five provinces (Nova Scotia, Quebec, Ontario, Saskatchewan and Alberta) have enacted specific enabling legislation applicable to X-rays and two (Nova Scotia and Saskatchewan) have issued regulations requiring registration of operators and equipment.

The Department provides a number of radiation protection services including external and internal personnel monitoring through its various personnel dosimetry services and its body burden assay service. In addition, it carries out radiation surveys and field studies to assess radiation hazards. The Department serves as the co-ordinator for the federal departments and agencies that are capable of providing specialized assistance in the event of radiation accidents involving possible exposure of members of the public. It also provides short-term training courses in radiation protection for persons with varying degrees of responsibility for radiation protection on a day-to-day basis.

The Department operates extensive laboratories for environmental monitoring and research. A comprehensive nation-wide monitoring program has been developed to assess the exposure of the public to radiation from radioactive fallout from nuclear weapons testing. The Department is assisted in the systematic collection of samples of air, precipitation, soil, wheat, milk and human bone by the federal Departments of Transport and Agriculture and by pathologists in hospitals throughout Canada. Reports of the concentrations of such fallout components as strontium -90 and cesium-137 in these samples are published monthly. Because of a unique food-chain cycle in the Far North, a special study of cesium-137 in the North has been developed

and this includes measurements of the concentration of cesium-137 in caribou and reindeer meat and in human urine. In addition, direct measurements of cesium-137 levels in living persons are made by means of portable and fixed "whole body counters".

There is an increasing need for better biological data on which to base estimates of radiation dose. The Department is developing several programs with this objective in mind. For example, it is using specialized facilities such as the whole body counter for radionuclide metabolism studies, i.e., of the intake, localization and elimination of radioactive substances such as cesium-137 and uranium. It is also carrying out research and development work in biological dosimetry, in an attempt to develop a practicable method of assessing the degree and effect of a suspected radiation exposure. The Department is thus improving its capability of providing medical advice concerning the follow-up of persons exposed to ionizing radiation.

Subsection 5 - Consultative and Technical Services

The extension of technical and consultative assistance to the provinces is a function of the Health Services Branch and the Health Insurance and Resources Branch of the Department of National Health and Welfare. The following specialized services supply consultation and information, advise on health care projects, co-ordinate activities and planning, and exercise leadership in promoting high standards of service: Child and Maternal Health; Dental Health; Emergency Health; Epidemiology; Health Education; Laboratory of Hygiene; Medical Rehabilitation; Mental Health; Nursing Services; Nutrition; Occupational Health; Radiation Protection; Public Health Engineering; Research Development; Health Grants; Health Resources; Hospital Insurance and Diagnostic Services; Health Facilities Design; Medical Care Insurance and Research and Statistics. In addition, the Information Services of the Department produces and distributes a variety of literature, films and radio programs to inform and educate the public on health subjects.

Subsection 6 - Special Programs

The Department of National Health and Welfare also carries out a number of specialized health services that are of national concern. Among these are the Emergency Health Services which assists provincial and municipal governments to organize emergency medical, nursing, hospital and public health services; the Laboratory of Hygiene including the Virus Laboratory which serves as the national reference centre for the diagnosis of bacterial and viral diseases of man; and the Radiation Protection Division that is mainly responsible for safety measures to protect Canadian radiation workers (see p. 11).

The Environmental Health Centre carries out specialized advisory and research services in occupational health, aerospace medicine, and public health engineering, which deals with health problems of interprovincial and international traffic and water resources management.

Section 2 - Federal-Provincial Health Activities

The Department of National Health and Welfare serves the provinces in an advisory and co-ordinating capacity and administers grants to provincial and voluntary health agencies. Administration of federal aspects of the Health Resources Fund and the Hospital Insurance and National Health Grants program is a major activity. Co-ordination with the provinces on health matters is facilitated by the Dominion Council of Health.

Subsection 1 - Medical Care

The Medical Care Act was passed by the Canadian Parliament in December 1966 and is to become operative not later than July 1, 1968. The provisions of this statute are based on principles outlined by the Prime Minister in July 1965, when he announced the intention of the Government to make available to the provinces federal financial contributions for provincially administered medical care programs.

In accordance with the terms of the Medical Care Act, the Government of Canada contributes to any participating province half the per capita cost of all insured services furnished under the plans of all participating provinces multiplied by the number of insured persons in that one province. In order to benefit from this federal contribution, a provincial plan must meet the following criteria:

(1) the plan must be operated on a non-profit basis by a public authority set up by the provincial government, subject in respect of its accounts and financial transactions to provincial audit;

(2) the plan must make available on uniform terms and conditions to all insurable residents of the province, insured services, which are defined as all medically necessary services rendered by medical practitioners, for whom the provincial law must provide reasonable compensation, so as to ensure reasonable access to insured services by insured persons;

(3) the plan must give entitlement to not less than 90 per cent of the number of eligible residents of the province during the first two years and not less than 95 per cent thereafter;

(4) for persons normally resident in Canada, the plan must not impose any minimum period of residence, although up to three months' waiting period for entitlement within a province is permissible if portability is provided for, so that persons retain coverage when temporarily absent from the province or during any required waiting period of not more than three months, for benefits in another province on change of residence.

In addition to the comprehensive physicians' services which must be provided as insured services by participating provinces, the Medical Care Act empowers the government to include any additional health services under terms and conditions which may be specified by the Governor-in-Council.

All insured services must be provided without exclusion because of age, ability to pay, or other circumstances.

The Canada Assistance Plan, described elsewhere in detail, provides for federal contributions of half the costs of health care services (as well as income maintenance) that provinces make available to persons establishing eligibility on the basis of financial need.

Subsection 2 - Health Resources Fund

Supplementing the medical care program is the Health Resources Fund, which supports the construction of research establishments, teaching hospitals, medical schools and training facilities for nurses and other professionals in the field of health care. The Health Resources Fund Act was enacted in July 1966, and supporting regulations were passed in February 1967. The Fund contains $500 million to be appropriated during the fifteen-year period 1966 to 1980, out of which the Government of Canada will pay up to one-half the costs of construction, acquisition, renovation and basic equipment for training and research facilities, including the costs of planning, but excluding the costs of land, interest, and lodgings. Of the $500 million, $300 million are to be distributed among the provinces in proportion to their population; $25 million go to the Atlantic Provinces for joint projects; the remainder of $175 million is yet to be allocated by the Government of Canada.

During the fiscal year 1966-67, the first year of the operation of the Act, four projects were approved, for which the contribution under the Act is $15 million.

Subsection 3 - National Health Grant Program

The National Health Grant program, inaugurated in 1948, makes federal grants available to the provinces for the developing and strengthening of public health and hospital services. Changes have been made over the years to provide additional funds, to increase flexibility, and to meet

changing circumstances. Table 1 shows the changes in the grants structure and the present arrangement under nine continuing grants as follows: Professional Training, Hospital Construction, Mental Health, Tuberculosis Control, Public Health Research, General Public Health, Cancer Control, Medical Rehabilitation and Crippled Children, and Child and Maternal Health. During the period from 1948 to 1966 the total grant expenditure was $663 million, representing 80 per cent of the available funds. This percentage increased during the period.

The largest single grant has been directed to hospital construction. Up to March 31st, 1967, assistance for construction of hospital beds and auxiliary accommodation had been approved for 125,898 hospital beds, and 15,636 bassinets, 24,012 beds for nurses, and 919 beds for interns. Continuing federal expenditure under the General Public Health Grant, the second largest grant, has assisted the provinces in maintaining and extending vigilance by local health personnel across the country against epidemiological and environmental health hazards. Since 1948 more than 46,000 health and hospital personnel have received grant funds for special training and in 1966-67 alone more than 6,000 health workers were employed with grant assistance. Other grants are designated for specific areas of service, such as the prevention and treatment of mental illness and tuberculosis, cancer control, reduction of infant mortality and improvement of maternity, infant and child care, medical rehabilitation and prevention and treatment of crippling conditions in children and adults.

Emphasis is changing in the research which is assisted under the Health Grants. Since September 1966, to be approved under the Public Health Research Grant a project must show a direct relationship to one of the following aspects of public health: prevention of disease or disability; operational or administrative studies to improve health services; epidemiological studies; or environmental health. Most research in medical science and in the clinical fields is therefore excluded from the Public Health Research Grant unless it bears some special relationship to the four areas mentioned. For consolidated account of medical and public health research see page 10.

TABLE 1 - AMOUNTS AVAILABLE AND AMOUNTS AND PERCENTAGES EXPENDED UNDER THE NATIONAL HEALTH GRANT PROGRAM, BY GRANT, FOR THE EIGHTEEN-YEAR PERIOD ENDED MARCH 31, 1966, AND FOR THE YEAR ENDED MARCH 31, 1967

GRANT	1948 - 1966 Period (1)			Year Ended March 31, 1967 (2)		
	Amount Available	Amount Expended	Percentage Expended	Amount Available	Amount Expended	Percentage Expended
	$	$		$	$	
Crippled Children (3)	6,207,728	4,431,677	71	-	-	-
Professional Training	17,191,644	16,547,735	96	1,411,376	1,447,950	103
Hospital Construction	282,419,132	233,945,344	83	20,367,320	16,473,944	81
Venereal Disease Control (4)	5,968,336	5,146,209	86	-	-	-
Mental Health	126,734,488	107,531,187	85	6,254,322	6,030,278	96
Tuberculosis Control	67,968,562	63,720,635	94	1,202,903	1,641,797	136
Public Health Research	18,640,558	16,286,456	87	4,501,330	4,242,903	94
Health Survey (5)	645,180	540,960	84	-	-	-
General Public Health	173,624,051	125,007,662	72	12,113,371	11,282,604	93
Cancer Control	62,489,353	45,476,985	73	1,387,630	1,122,426	81
Laboratory and Radiological Services (6)	47,404,300	14,450,881	30	-	-	-
Medical Rehabilitation (7)	6,500,000	3,016,750	46	-	-	-
Medical Rehabilitation and Crippled Children (8)	16,410,550	11,157,137	68	2,071,457	1,876,895	91
Child and Maternal Health (9)	22,173,700	15,320,900	69	1,351,012	826,809	61
TOTAL	824,377,582	662,580,518	80	50,660,721	44,945,606	89

(1) Amounts available as set out in the Orders-in-Council and amounts expended for all types of grants to all provinces.
(2) Figures for the year ended March 31, 1967 apply to grant allocations and payments for public health research and hospital construction in all provinces but exclude the respective amounts under all other types of grants which apply to Quebec. A total of $10,113,679 in amounts available to Quebec and an estimated expenditure of $9,600,000 representing Quebec's share through tax rebate under the Established Programs (Interim Arrangements) Act are therefore not included. Distribution by grant of the 1966-67 payments made to Quebec will be available for inclusion in the next edition. Expenditures may exceed 100 per cent of amounts available through transfer of unexpended funds from one grant to another or, in the case of the Hospital Construction grant, through revote of funds unused in previous years.
(3) Merged with Medical Rehabilitation Grant, April 1, 1960.
(4) Absorbed into General Public Health Grant, April 1, 1960.
(5) Lapsed in 1953 following the completion of provincial health surveys.
(6) Introduced in 1953 and absorbed into General Public Health Grant, April 1, 1960.
(7) Introduced in 1953 and merged with Crippled Children Grant, April 1, 1960.
(8) Amounts for 1960-66 only; see footnotes 3 and 7.
(9) Introduced in 1953.

Subsection 4 - Hospital Insurance

Provincial hospital insurance programs, operating in all provinces and territories since 1961, cover 99 per cent of the population of Canada. The programs were introduced under the Hospital Insurance and Diagnostic Services Act of 1957, by which the Government of Canada shares with the provinces the cost of providing specified hospital services to insured patients. Specifically excluded are tuberculosis hospitals and sanatoria, hospitals or institutions for the mentally ill, as well as institutions, the purpose of which is the provision of custodial care, such as nursing homes and homes for the aged. The methods of administering and financing the program in each province and the provision of services above the stipulated minimum that is required by the Act are left to the choice of the province.

Insured in-patient services must include accommodation, meals, necessary nursing service, diagnostic procedures, pharmaceuticals, the use of operating rooms, case rooms, anaesthetic facilities, and the use of radiotherapy and physiotherapy if available. Similar out-patient services may be included in provincial plans and authorized for contribution under the Act. All provinces include some out-patient services. The provincial plans are administered by the provincial department of health in some provinces and by a separate commission in others. To finance the insurance plans, the provinces use general revenue, sales taxes and premiums in various combinations.* The Government of Canada contributes out of the consolidated revenue fund in respect to each province, the sum of 25 per cent of the per capita cost of in-patient services in Canada and 25 per cent of the per capita cost of in-patient services in the province, which is then multiplied by the average number of insured people in that province. Thus the total

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* These are: general revenue only: Newfoundland, Prince Edward Island, New Brunswick, Quebec and the Yukon; general revenue and a daily charge at the time of service: Alberta, British Columbia, and the Northwest Territories; general revenue and sales tax: Nova Scotia; general revenue, premiums, and sales tax: Saskatchewan; general revenue and premiums: Ontario and Manitoba.

contribution is about 50 per cent of the sharable cost for all Canada, but the proportion is higher for provinces where the per capita cost is below average and lower for the other provinces. Contributions for insured out-patient services with respect to each province are paid in the same proportion as the contributions to the cost for in-patients.*

Tables 2 to 11, unless otherwise stated, contain statistics on the hospitals that are listed in the federal-provincial hospital insurance agreements. Most of these are "budget review" hospitals, that is hospitals whose budgets have to be approved by provincial government authority. They are publicly owned general and special hospitals. "Contract" hospitals are not publicly owned; they provide care to insured patients under contract with the provincial agency. Hospitals of the Government of Canada are operated by the Departments of National Health and Welfare, Veterans Affairs, and National Defence.

Table 2 shows that 1,290 hospitals were listed in the federal-provincial agreements at the end of 1965. Of these, 1,277 submitted annual reports and are represented in Table 3. The total number of beds in the reporting hospitals at the end of 1965 was 134,619, which amounts to 6.9 beds per thousand population. This bed-population ratio ranged from 5.8 in Newfoundland and Prince Edward Island to 19.0 in the Northwest Territories. Among the ten provinces, the ratio was highest in Saskatchewan and Alberta at 8.3.

Table 4 records a total of 39.6 million patient-days in hospitals that are listed in the agreements, of which 35.9 million or 91 per cent were paid for by the insurance plan of the reporting province. This corresponds to a rate of 2,023 patient-days per thousand population for Canada. The rate ranged from 1,501 in Newfoundland to 2,355 in Saskatchewan and 2,521 in the Northwest Territories.

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* Since January 1st, 1965, contributions to Quebec under the Hospital Insurance and Diagnostic Services Act have been discontinued and been replaced by arrangements under the Established Programs (Interim Arrangements) Act.

TABLE 2 - NUMBER OF HOSPITALS AND OTHER FACILITIES LISTED IN HOSPITAL INSURANCE AGREEMENTS, BY STATUS, CANADA AND PROVINCES, DECEMBER 31st, 1963

Province	Hospitals				Other facilities(a)			Total
	Budget review	Contract(b)	Gov't of Canada	Total	Budget review	Contract	Total	
Newfoundland	43	3	1	47	-	1	1	48
Prince Edward Island	9	-	-	9	-	1	1	10
Nova Scotia	47	-	1	48	-	2	2	50
New Brunswick	38	-	2	40	-	1	1	41
Quebec	169	91	11	271	4	2	6	277
Ontario	218	86	14	318	-	4	4	322
Manitoba	80	6	16	102	1	1	2	104
Saskatchewan	153	5	3	161	5	3	8	169
Alberta	133	2	8	143	3	16	19	162
British Columbia	98	15	6	119	-	1	1	120
Yukon	2	-	3	5	-	1	1	6
Northwest Territories	2	7	18	27	-	1	1	28
Canada	992	215	83	1,290	13	34	47	1,337

(a) Includes clinics and medical centres, laboratories, radiological facilities, and Red-Cross blood depots.

(b) Excludes the three listed hospitals in the U.S.A.

TABLE 3 - BEDS(a) IN REPORTING HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS, NUMBER AND RATIO PER 1,000 POPULATION(b) CANADA AND PROVINCES, DECEMBER 31st, 1965

Province	Hospitals reporting	Beds	
		Number	Ratio per 1,000 population
Newfoundland	47	2,867	5.8
Prince Edward Island	9	629	5.8
Nova Scotia	48	4,749	6.2
New Brunswick	40	4,049	6.5
Quebec	268	35,862	6.3
Ontario	314	46,741	6.9
Manitoba	101	7,004	7.3
Saskatchewan	158	7,929	8.3
Alberta	142	12,073	8.3
British Columbia	119	12,081	6.8
Yukon	5	160	10.7
Northwest Territories	26	475	19.0
Canada	1,277	134,619	6.9

(a) Excludes bassinets
(b) Estimated as on June 1st, 1965, Dominion Bureau of Statistics.

TABLE 4 - TOTAL PATIENT-DAYS AND INSURED PATIENT-DAYS IN HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS, NUMBER AND RATE PER 1,000 POPULATION, CANADA AND PROVINCES, 1965

Province	Hospitals reporting	Total patient-days		Patient-days paid for by the insurance plan of the reporting province	
		Number	Rate(a)	Number	Rate(b)
Newfoundland	48	747,716	1,501	695,012	1,398
Prince Edward Island	9	176,112	1,631	167,557	1,581
Nova Scotia	48	1,308,903	1,720	1,176,141	1,585
New Brunswick	40	1,191,804	1,913	1,079,196	1,755
Quebec	270	10,781,567	1,906	9,926,175	1,760
Ontario	318	14,250,832	2,117	12,861,580	1,941
Manitoba	101	1,986,113	2,065	1,767,170	1,868
Saskatchewan	158	2,239,828	2,355	2,136,074	2,275
Alberta	142	3,342,869	2,304	3,105,432	2,157
British Columbia	119	3,486,850	1,949	2,941,211	1,657
Yukon	5	23,898	1,593	20,649	1,377
Northwest Territories	26	63,014	2,521	38,340	1,534
Canada	1,284(c)	39,599,506	2,023	35,914,537	1,855

(a) Per 1,000 population (estimated as on June 1st, 1965).
(b) Per 1,000 persons, insured under provincial plans.
(c) Includes 7 hospitals that closed during the year.

Table 5 shows average length of hospital stay and occupancy ratios for budget review hospitals only. Average length of stay of patients who were discharged from or who died in hospitals during 1965, except in the Northwest Territories, ranged from 8.9 days in Alberta to 11.2 days in Newfoundland, with an average of 10.2 days. Length of stay in chronic hospitals is much longer and varies greatly from province to province. In the seven reporting convalescent hospitals, the average length of stay was 43.4 days.

The occupancy ratio in general hospitals was 80.5 per cent in 1965, the same as in 1964; 91.4 per cent in chronic hospitals; and 82.4 per cent in convalescent hospitals. Since occupancy varies with the size of hospital, variations in the occupancy ratio among provinces can be partially attributed to this factor. Thus, Quebec, Ontario, and British Columbia, where there are many large hospitals, show the highest occupancy in general hospitals, and the Territories, the lowest.

Table 6 shows 3.2 million separations (discharges and deaths) from all reporting hospitals that were listed in insurance agreements. This corresponds to a rate of 161 per thousand population. Variations among provinces are rather large with the highest rate (Northwest Territories) being more than twice the lowest (Newfoundland).

Table 7 shows 231,387 full-time employees at the end of 1965, which is 12,615 or 5.8 per cent more than the year before, while the number of part-time employees increased by 3,087 to 28,592.

Tables 8 and 9 deal with revenue fund expenditures of budget review hospitals only. These exclude capital costs, but include expenditures for services that are not covered by hospital insurance plans. The expenditures increased by 13 per cent over the preceding year to $1,109 million, of which salaries accounted for two-thirds.

Expenditures per patient-day ranged from $24.41 in Prince Edward Island to $36.95 in Quebec, except for the Yukon where the cost per patient-day was $51.73. Regional differences reflect not only differences in the cost of

TABLE 5 - AVERAGE LENGTH OF STAY(a) AND OCCUPANCY(b) FOR BUDGET REVIEW GENERAL, CHRONIC, AND CONVALESCENT HOSPITALS, CANADA AND PROVINCES, 1965

Province	General hospitals			Chronic hospitals			Convalescent hospitals		
	Reporting hospitals	Average length of stay	Occupancy	Reporting hospitals	Average length of stay	Occupancy	Reporting hospitals	Average length of stay	Occupancy
	Number	Days	Per cent	Number	Days	Per cent	Number	Days	Per cent
Newfoundland	42	11.2	78.0	-	-	-	-	-	-
Prince Edward Island	8	9.8	77.1	-	-	-	-	-	-
Nova Scotia	44	10.6	75.6	-	-	-	1	39.3	84.3
New Brunswick	36	10.0	81.4	[1](c)	49.2	96.2	-	-	-
Quebec	128	10.3	81.5	25	181.7	93.9	3	47.3	74.0
Ontario	193	10.9	82.9	19	261.0	91.6	4	41.6	90.2
Manitoba	76	9.3	78.5	4	121.5	87.3	-	-	-
Saskatchewan	148	9.5	75.9	4	262.4	95.1	-	-	-
Alberta	106	8.9	74.4	23	175.3	86.2	-	-	-
British Columbia	86	9.3	81.8	5	385.1	96.5	-	-	-
Yukon	2	5.9	30.0	-	-	-	-	-	-
Northwest Territories	2	7.2	55.5	-	-	-	-	-	-
Canada	873	10.2	80.5	80	197.9	91.4	8	43.4	82.4

(a) Patient-days since admission divided by number of separations (Excluding the newborn).
(b) Ratio of the average number of patients to the average number of available beds.
(c) Chronic unit of a general hospital.

TABLE 6 - SEPARATIONS(a) FROM HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS, NUMBER AND RATE PER 1,000 POPULATION(b) CANADA AND PROVINCES, 1965

Province	Reporting hospitals	Separations	
		Number	Rate per 1,000 population
Newfoundland	84	64,639	130
Prince Edward Island	9	17,726	164
Nova Scotia	48	114,778	151
New Brunswick	40	108,561	174
Quebec	270	797,040	141
Ontario	318	1,051,620	156
Manitoba	101	171,676	178
Saskatchewan	158	212,052	223
Alberta	142	287,440	198
British Columbia	119	316,285	177
Yukon	5	2,825	188
Northwest Territories	26	6,554	262
Canada	1,284	3,151,196	161

(a) Excludes the newborn.
(b) Estimated as on June 1st, 1965, Dominion Bureau of Statistics.

TABLE 7 - PERSONNEL IN HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS(a) CANADA AND PROVINCES, DECEMBER 31st, 1965

Province	Number of hospitals	Number of employees	
		Full-time	Part-time
Newfoundland	47	4,637	168
Prince Edward Island	9	1,032	85
Nova Scotia	48	8,467	830
New Brunswick	40	7,673	666
Quebec	271	71,500	6,091
Ontario	318	80,376	13,429
Manitoba	102	11,397	2,092
Saskatchewan	161	11,368	1,293
Alberta	143	16,907	1,699
British Columbia	119	17,537	2,175
Yukon	5	152	5
Northwest Territories	27	341	59
Canada	1,290	231,387	28,592

(a) Includes estimates for 15 hospitals that did not report.

TABLE 8 - REVENUE FUND EXPENDITURES OF BUDGET REVIEW HOSPITALS
CANADA AND PROVINCES, 1965

Province	Number of reporting hospitals	Total expenditures	Expenditures per patient-day(a)	Expenditures per capita(b)
		$'000's	$	$
Newfoundland	43	20,562	28.91	41.29
Prince Edward Island	9	4,299	24.41	39.81
Nova Scotia	47	37,619	32.06	49.43
New Brunswick	38	32,892	29.98	52.80
Quebec	169	338,465	36.95	59.83
Ontario	217	401,415	32.14	59.64
Manitoba	80	49,387	27.90	51.34
Saskatchewan	144	54,825	27.72	57.65
Alberta	133	80,231	26.08	55.29
British Columbia	98	88,864	30.55	49.67
Yukon	2	147	51.73	9.83
Northwest Territories	2	417	30.24	16.67
Canada	982	1,109,123	32.09	56.67

(a) Excludes the newborn.
(b) Based on population estimates as on June 1st, 1965, Dominion Bureau of Statistics.

labour and material, but also the proportion of care of geriatric and convalescent patients, which is less costly than care for acute illness; provinces vary in the proportion of this care that is provided in budget review hospitals. The average for Canada was $32.09 per patient-day in 1965, 10 per cent higher than in 1964.

Although budget review hospitals provided only about 88 per cent of all insured patient-days, the table shows also the per capita amount of their expenditures. This varies greatly between provinces, mainly on account of differences in hospital utilization (patient-days per person per year) and of the aforementioned varying proportion of geriatric and convalescent care that budget review hospitals provide.

Table 9 shows that the largest cost component was salaries, 65.3 per cent of the total. This item has been increasing more than the other components. It reflects the increased staff-patient ratio and increases in salaries as well as the greater use of special skills that modern hospital care requires.

Tables 10 and 11 show the data on patients whose date of separation (discharge or death) was in the year 1965. Table 10 shows the amount of use that people make of hospital care (patient-days since admission per 1,000 population) and the average length of hospital stay, for different age groups and by sex. Table 11 shows cases per thousand population and average length of hospital stay specific for twelve diagnostic categories.

Subsection 5 - Dominion Council of Health

The Dominion Council of Health, established in 1919, advises the Minister of National Health and Welfare on matters relating to the promotion and preservation of the health of the people of Canada. It meets twice a year and consists of the Deputy Minister of National Health, who acts as chairman, and of the chief executive officer of the department of health of each province, as well as up to five persons whom the Governor in Council appoints for a period of three years. Traditionally these are chosen from the field

TABLE 9 - REVENUE FUND EXPENDITURES OF BUDGET REVIEW HOSPITALS BY TYPE OF ACCOUNT, CANADA, 1965

Item	Total expenditures	Expenditures per patient-day(a)	Expenditures per capita(b)	Percentage distribution
	$'000's	$	$	
Salaries and wages	723,731	20.94	36.98	65.3
Medical and surgical supplies	34,199	0.99	1.75	3.1
Drugs	42,251	1.22	2.16	3.8
Raw food	54,975	1.59	2.81	5.0
Other expenses(c)	253,967	7.35	12.97	22.9
Total	1,109,123	32.09	56.67	100.0

(a) Excludes the newborn.

(b) Based on population estimates as on June 1st, 1965, Dominion Bureau of Statistics.

(c) Includes other supplies, electricity, maintenance, services, repairs, interest, depreciation, rent, etc.

TABLE 10 - SEPARATIONS AND DAYS OF CARE SINCE ADMISSION FOR PATIENTS(a) INSURED BY PROVINCIAL PLANS, BY SEX AND AGE, CANADA, 1965

Item	0-4	5-14	15-24	25-44	45-59	60-64	65-74	75 and over	All ages
Separations									
Male	216,459	190,374	120,506	221,708	209,514	69,226	123,065	104,587	1,256,[illegible](b)
Female	159,406	162,81[illegible]	377,873	638,268	235,520	61,204	115,007	101,771	1,853,[illegible](b)
Total	375,865	353,184	498,379	859,976	445,034	130,430	238,072	206,358	3,110,[illegible](b)
Separations per 1,000 population(c)									
Male	187	87	75	90	147	216	279	398	127
Female	144	78	243	260	167	192	239	330	170
Total	166	83	158	175	157	204	258	361	149
Patient-days since admission									
Male	1,794,659	1,169,945	976,553	2,289,853	3,011,121	1,206,913	2,599,224	2,937,613	16,000,563
Female	1,341,280	947,833	2,426,608	5,187,063	3,314,347	1,135,169	2,716,633	3,750,953	20,439,[illegible]
Total	3,135,939	2,117,778	3,403,161	7,476,916	6,325,468	2,342,082	5,315,857	6,688,566	36,440,341
Days since admission per 1,000 population(c)									
Male	1,552	538	609	926	2,106	3,770	5,874	11,132	1,622
Female	1,215	456	1,562	2,113	2,351	3,552	5,649	12,[illegible]50	2,147
Both sexes	1,388	498	1,078	1,518	2,228	3,661	5,757	11,[illegible]10	1,[illegible]82
Average length of stay (days)									
Male	8.3	6.1	8.1	10.3	14.4	17.4	21.1	28.1	12.[illegible]
Female	8.4	5.8	6.4	8.1	14.1	18.5	23.6	36.[illegible]	11.[illegible]
Both sexes	8.3	6.0	6.8	8.7	14.2	18.0	22.3	32.[illegible]	11.[illegible]

a) Excludes the newborn.
(b) Includes cases where the age was not stated.
(c) Based on population estimates as on June 1st, 1965, Dominion Bureau of Statistics.

Source: Provincial Plans

TABLE 11 - DIAGNOSES OF PATIENTS(a) INSURED BY PROVINCIAL PLANS(b) CANADA, 1965

Section of the International Classification of Diseases	Separations		Patient-days since admission		Average length of stay (days)	Percentage distribution	
	Number	Rate per 1,000(c) population	Number	Rate per 1,000(c) population		Separations	Patient-days
I. Infective and parasitic diseases	42,622	2.2	564,711	28.9	13.2	1.4	1.5
II. Neoplasms	172,203	8.8	3,245,766	165.8	18.8	5.6	8.9
III. Allergic, endocrine system, metabolic, and nutritional diseases	90,849	4.6	1,426,472	72.9	15.7	2.9	3.9
IV. Diseases of the blood and blood-forming organs	17,720	0.9	270,212	13.8	15.2	0.6	0.7
V. Mental, psychoneurotic, and personality disorders	88,692	4.5	1,548,328	79.1	17.5	2.9	4.3
VI. Diseases of the nervous system and sense organs	155,121	7.9	3,878,884	198.2	25.0	5.0	10.7
VII. Diseases of the circulatory system	250,936	12.8	5,186,693	265.0	20.7	8.1	14.3
VIII. Diseases of the respiratory system	482,284	24.6	3,237,002	165.4	6.7	15.6	8.9
IX. Diseases of the digestive system	420,236	21.5	4,311,558	220.3	10.3	13.6	11.9
X. Diseases of the genito-urinary system	255,609	13.1	2,442,877	124.8	9.6	8.3	6.7
XI. Deliveries and complications of pregnancy, childbirth, and the puerperium	553,082	28.3	3,182,206	162.6	5.8	17.9	8.8
XII. Diseases of the skin and cellular tissue	60,532	3.1	603,243	30.8	10.0	2.0	1.7
XIII. Diseases of the bones and organs of movement	108,820	5.6	2,059,508	105.2	18.9	3.5	5.7
XIV. Congenital malformations	31,715	1.6	465,848	23.8	14.7	1.0	1.3
XV. Certain diseases of early infancy	10,473	0.5	141,018	7.2	13.5	0.3	0.4
XVI. Symptoms, senility, and ill-defined conditions	76,650	3.9	592,355	30.3	7.7	2.5	1.6
XVII. Accidents, poisonings, and violence	275,124	14.1	3,184,053	162.7	11.6	8.9	8.8
All diagnoses	3,092,668	158.0	36,340,734	1,856.9	11.8	100.0	100.0

(a) Excludes the newborn and certain special cases, such as examinations, inoculations, fittings, etc. (Y00-Y18, Y40-Y88 of the International classification of diseases).
(b) Some provinces included cases that were not paid for under their plans. Others excluded insured cases where the patients were treated outside the province. Saskatchewan excluded data from four geriatric hospitals.
(c) Estimated as on June 1st, 1965, Dominion Bureau of Statistics.

of agriculture, medical science, organized labour, and from women's organizations.

The Council is supported by special advisory committees who deal with specific aspects of public health and who are appointed by Order in Council.

Section 3 - Provincial and Local Health Services

Provincial governments are mainly responsible for the various measures to preserve the health of individuals and communities. These are administered by official and voluntary health agencies, hospitals, and teaching and research institutions in co-operation with the health professions. Health services fall into the broad categories of public health, hospital services, and medical care programs; as well as general programs, there are organized services for specific diseases and for the chronically ill and disabled.

Although the pattern of services is somewhat similar, provincial governments vary as to health legislation and methods of financing and administering different programs. Most health functions are exercised by the provincial health departments, but in some provinces, certain programs such as hospital insurance, medical care insurance, tuberculosis control, cancer control or alcoholism programs may be administered by separate public agencies directly accountable to the minister of health. Voluntary organizations also provide specialized health services often with some support from tax funds in the form of payment for services or support grants.

In general, the provincial health departments carry out overall planning and direction of public health programs, administer certain specialized health programs, and assist through technical and financial aid the regional or county health units and city health departments that have been delegated responsibility for the basic public health services. In most provinces, the health unit systems, which serve mainly rural areas, are operated either by the province or jointly by the province and the local authority, with the local authority having jurisdiction over county, municipality

or larger area, while city health departments are administered by municipal or metropolitan boards of health. Several provincial health departments also directly administer health services to northern unorganized territories. The nucleus staff of a local health unit or department usually is composed of a full-time medical officer of health, a number of public health nurses and a public health inspector.

Local programs to safeguard community health are concerned with environmental sanitation to ensure safe water, milk, and other foods, prevention and control of infectious diseases, the improvement of maternal, child, and school health services, dental health, and health education of the public. In addition, the larger city health departments have developed specialized services in such areas as mental health, home care, and rehabilitation of the chronically ill and the handicapped. More recently a few health units and departments have started health screening for chronic conditions and family planning clinics. The city health departments also participate in some degree with the provincial authorities in accident prevention and in measures to control air, water, and soil pollution.

Provincial health departments support the local programs by health grants and the provision of technical consultant services. Most of the mental and tuberculosis hospitals and clinics are operated provincially, as are treatment services for the venereal diseases, cancer, alcoholism and other specific diseases, and the laboratories that aid in diagnostic and control procedures. The provincial agencies are primarily responsible for the collection and analysis of vital statistics and the study of the epidemiological and related social and economic conditions that affect health. They also give leadership in such fields as occupational health, nutrition, health education, and pollution control, in collaboration with national health agencies. In order to maintain and improve the health services, the provincial health departments recruit and train professional and technical personnel and support public health research.

Subsection 1 - Public Health Services

Environmental health. - The control of factors in the environment that are harmful to health is an expanding area of public health. Much of the work in community sanitation involves inspection duties to maintain safe milk, water, and food supplies and sanitary conditions in sewage and waste disposal systems and in public areas such as camp sites and swimming pools. Air pollution, water pollution, radiation exposure, and the use of pesticides have become major problems, necessitating the co-operative efforts of governments and other agencies in research and in planning effective control measures. Special water authorities in Ontario and Quebec have responsibility for all aspects of public water supply, sewage systems, and stream pollution, while six other provinces have special water agencies exercising similar functions jointly with the health departments.

Occupational health. - Services designed to prevent accidents and occupational diseases and to maintain the health of employees are the common concern of provincial health departments, labour departments, workmen's compensation boards, and industrial management. Provincial agencies regulate working conditions and offer consultant and educational services to industry. All provinces have legislation (factory acts, shop acts, mines acts, workmen's compensation acts) setting health safety standards for employment. A majority of provinces maintain environmental health laboratories for the study of industrial health problems such as the effects of noise and atmospheric conditions on workers.

Communicable disease control. - Five provincial health departments have separate divisions of communicable disease control headed by full-time epidemiologists; in the other provinces these functions are handled by other provincial medical consultants. Local health authorities undertake case-finding and diagnostic services in co-operation with public health laboratories, conduct epidemiological investigations and carry out control measures such as those for tuberculosis and venereal disease. All provincial health departments organize immunization programs against diphtheria, tetanus, poliomyelitis, whooping cough, and

smallpox, and in most provinces against measles. Through agreement with the federal government, live oral poliovirus vaccine (Sabin) as well as Salk vaccine is made available by provincial health departments for immunization against poliomyelitis.

Maternal and child health. - All provincial health departments have established consultant services on maternal and child health: five provinces have separate divisions under medical direction, and nine have public health nursing divisions that work with the local health services in this field. The specialized divisions also undertake studies in maternal and child care, including hospital care, and assist in the training of nursing personnel.

Dental health. - All provincial health departments have dental health divisions that administer programs varying under local conditions but directed almost entirely to health education and the care of children. Training of dentists and dental hygienists in public health, the operation of children's preventive and treatment clinics, and health education are primary concerns in all provinces. In general, dental care is restricted to pre-school and the younger school age groups, although mobile dental clinics are extended to children living in remote areas where no dentist is available. Several provinces have set up, in conjunction with their dental schools, special courses for dental hygienists. Locally sponsored plans in which the cost of dental services for children is shared by the community and the provincial health departments are in operation in most provinces.

Nutrition. - Consultants in nutrition give technical guidance and education to health and welfare agencies and hospitals, and diet counselling to selected patient groups; they also conduct surveys in nutrition and other research.

Health education. - A basic concern of provincial health authorities is to stimulate public interest in important health needs. Most provincial health departments have a division or unit of health education under a full-time professional "health educator". It provides educational materials to other divisions of the health department, to local health authorities and to voluntary associations.

Many educational activities are directed to reducing habits harmful to health such as cigarette smoking and the excessive use of alcohol and other drugs.

Public health laboratories. - All provinces maintain a central public health laboratory and most have branch laboratories to assist local health agencies and the medical profession in the protection of community health and the control of infectious diseases. Public health bacteriology (testing of milk, water, and food), diagnostic bacteriology, and pathology are the principal functions of the laboratory service, with medical testing for physicians and hospitals steadily increasing in volume. Efforts to co-ordinate public health and hospital laboratory services and measures to bring laboratory facilities to rural areas are among the recent developments.

Subsection 2 - Services for the Mentally Ill and the Mentally Retarded

Treatment programs for the mentally ill have centered mainly around three types of facilities: the mental hospital, the psychiatric unit in the general hospital, and the community mental health clinic; and of course the general practitioner and the psychiatrist in private practice. But these are becoming increasingly less separate and distinct in their functioning as the mental health movement concerns itself with wider community involvement in the psycho-social problem of mental illness. Treatment is being made more readily accessible with the expansion of psychiatric hospitals for short-term in-patient therapy, day care, emergencies, and out-patient services. The development of social centres and sheltered workshops to aid the mental patient after his discharge to the community owes much to the volunteer efforts of the Canadian Mental Health Association and the helpful response of individual residents. Mental hospitals provide a variety of ancillary programs, such as recreational and occupational therapy, vocational guidance, and industrial therapy to hasten discharge and make the patients' adjustments to the community easier.

Special centres for the assessment and diagnostic evaluation of mentally retarded and emotionally disturbed children are also being developed. Day-schools or classes for the trainable retarded, sponsored by local parent groups of the Canadian Association for Retarded Children, are organized throughout Canada and research programs designed to afford better understanding and management of mental retardation problems are being developed and expanded in all provinces.

The large public mental hospitals care for many types of mental illness. In recent years the status of many long-term chronically ill patients has been under review to determine their need for continued stay. As a result, it has been possible to resettle in community foster homes or boarding homes many patients who no longer require hospital care and treatment. In Ontario, for example, more than 2,000 mental hospital patients requiring sheltered care are in approved homes for special care, and others, chiefly ambulatory, are in approved boarding homes. In Saskatchewan, under a similar program of community placement, the mental hospital population has been reduced by at least 1,000.

Since 1961 six provinces - Nova Scotia, Ontario, Manitoba, Saskatchewan, Alberta, and British Columbia - have passed new legislation in respect to the care of the mentally ill to bring the legislation into accord with current psychiatric thought. In particular, the new legislation is designed to promote more informal methods of admission and discharge and to establish procedures for periodic review of the status of patients.

A great part of the cost of care in hospitals for the mentally ill and the mentally retarded is borne by the provincial governments, although a charge, according to ability to contribute, may be made in some provinces. Newfoundland and Saskatchewan provide institutional care at government expense; Manitoba covers minimum maintenance costs for all patients; in Nova Scotia the cost of care to patients requiring active treatment is borne by the province; and in Ontario all mental-institution treatment is included in the provincial hospital care insurance plan.

Subsection 3 - Services for Specific Diseases or Disabilities

Tuberculosis - The fight against tuberculosis is one of the major programs of all health departments. Hospitalization and drug treatments, both on an in-patient and a domiciliary basis, are provided free of charge. In two provinces extensive BCG vaccination programs are in effect and in the other provinces this prophylactic is provided to groups at special risk. Case finding programs in the form of community tuberculin and X-ray surveys, surveys of high risk groups, and the follow-up of arrested tuberculosis cases are routine. There has been a steady decline in the Canadian tuberculosis death rate to 3.6 per 100,000 population in 1965. Treatment in hospital for tuberculosis patients has also greatly declined with the use of drugs.

Cancer - Health departments and lay and professional groups working for the control of cancer have been mainly concerned with four aspects of the problem: diagnosis, treatment, research, and public education. In cancer detection and treatment, specialized medicine, hospital services, and public health programs are closely related. Programs operate under health departments in three provinces; four others support cancer agencies or commissions; in the remaining provinces support hospital-administered tumour clinics. Under the provincial hospital insurance plans, the benefits pertaining to insured in-patient services are the same in all provinces and include such special services, related to the treatment of cancer, as diagnostic radiology, laboratory tests and radiotherapy. Similar services for out-patients are covered either by hospital insurance or by federal-provincial cancer control grants. Comprehensive free medical programs for cancer patients are in operation in Saskatchewan and Alberta and, for cancer in-patients only, in New Brunswick.

Venereal disease. - Free diagnostic and treatment services are available in all provinces but the operation of government clinics is being increasingly superseded by supplying free drugs to private physicians and reimbursing them for treatment of indigents on a fee-for-service basis.

Alcoholism. - Within the past two decades provincially supported programs of varying scope have come into being to prevent and control alcoholism. Some are administered directly by the health departments; others by alcoholism foundations. The oldest and most extensive program is that of the Ontario Alcoholism and Drug Addiction Research Foundation whose activities include public and professional education, basic and clinical research and the operation of treatment facilities for in-patients and out-patients. Treatment facilities for alcoholic prisoners are being developed by correctional institutions in three provinces. Also the rehabilitation programs of various religious and other voluntary organizations assist many alcoholics.

Other diseases or disabilities. - Service organizations for persons with other specific conditions such as arthritis, cerebral palsy, diabetes, visual and auditory impairments, paraplegia and neurological conditions have been developed largely by voluntary agencies assisted by federal and provincial funds (see p.48).

Subsection 4 - Public Medical Care Programs

Provincial medical care plans. - Traditionally patients have paid directly for personal health care services. For the services of physicians, especially, prepaid insurance has been replacing direct payment. Thus, at the end of 1965 about 12 million Canadians or 61 per cent of the population had some voluntary insurance protection against the cost of physicians' services.

Government financing of personal health care has been increasing in two directions concurrently.

First, for the indigent, most provincial governments have assured payments to physicians and several, as well, to dentists, pharmacists for prescribed drugs, optometrists, and others. Such programs have operated in several provinces for many years. The remaining provinces have recently made similar provisions. Under the Canada Assistance Plan, the cost of the services can be shared by the Government of Canada.

Second, for the general population, some provincial governments have introduced programs intended to ensure, if necessary by using tax revenue, that all residents can have physicians' services insurance. In Saskatchewan, coverage is compulsory and no other agency is permitted to compete in the service area covered by the public plan. In British Columbia since 1965 and in Ontario since 1966, public agencies administer optional programs available to individual applicants. In Alberta in 1963 the government established minimum benefits and maximum premiums for existing voluntary insurance plans. In 1967 this arrangement was superseded by a plan similar to those in British Columbia and Ontario.

The British Columbia and Alberta schemes cover a comprehensive range of physicians' services, and also make provision for other health-care benefits to be included as part of the basic contract or as options at a somewhat higher premium cost.

As of mid-1967 the publicly-administered plans in British Columbia, Alberta, and Ontario offered individual contracts only. Private voluntary agencies continued to offer group contracts.

In Newfoundland, the population in the Cottage Hospital Districts (i.e., isolated outlying areas) may enrol in a medical service scheme. (Additionally, all children under 16 years of age throughout the province are covered under the Children's Health Service, at no direct charge to their families, for physicians' services in hospital.)

All these plans except the Children's Health Service use premiums. To ensure that the premium burden upon individuals is not too heavy, Saskatchewan and Newfoundland cover about three-quarters of the total cost from general tax revenues. In Ontario, Alberta, and British Columbia premiums of the needy, as defined by a simple test of income adequacy, are subsidized from general tax revenues. British Columbia also uses a special taxation-supported fund to help stabilize premium levels.

Saskatchewan - Only Saskatchewan has a universal-coverage medical care program. This program, which was introduced in July 1962, requires enrolment of the entire eligible population. The premiums are compulsory. The premium for a family is $24 per year; for a single person, $12. The premiums cover approximately 25 per cent of the costs of the program.

Among the medical services covered are home, office and hospital visits, surgery, obstetrics, psychiatric care, anaesthesia, laboratory and radiological services, preventive medicine, and certain services provided by dentists. There are no waiting periods for benefits and no exclusions for reasons of age or pre-existing health conditions.

Physicians may elect to receive payment in four ways. First, the physician may receive payment of 85 per cent of the tariffs in the current schedule of fees of the organized profession, directly from the public administering authority, and accept this payment as payment in full. Secondly, patients and physicians may enrol voluntarily with an "approved health agency" that serves as intermediary, with respect to payment, between the public authority and the physicians; here also, the physician receives 85 per cent of the tariff as payment in full. Thirdly, a physician may elect to submit his bill directly to the patient who pays him and seeks reimbursement for 85 per cent of the approved amount from the public authority; the physician may bill the patient directly for amounts over and above what the public authority has paid. Fourthly, patient and physician may, if they agree, settle their accounts privately without involving any public authority or approved health agency.

The following statistics for the year 1966 relate to operations of the Medical Care Insurance Plan and do not represent the total public involvement in medical care in Saskatchewan. Payments for medical services are also made by such other public agencies as the Hospital Services Plan, the Cancer Commission, the Antituberculosis League, the Workmen's Compensation Board, the Swift Current Health Region Board (a separate administering agency for insured services, covering about 55,000 insured residents in the Swift Current Region), and other provincial and federal agencies paying for services provided to certain groups in the population excluded from Medical Care Insurance coverage.

A total of about 612,000 residents received benefits of $22,207,281 during the year. Of this amount $14,479,553 was paid through approved health agencies, $6,183,516 paid directly to physicians, and $1,531,071 directly to patients.

Payments per person covered increased to $25.69 in 1966. This represents an increase of 6.2 per cent over 1965.

Payment for one or more services was made to 612,000 individual beneficiaries, comprising 71 per cent of the covered population. Of families covered, 84 per cent received one or more services. For the families receiving benefits the average payment was $78.12.

About 61 per cent of families receiving benefits actually received benefits of $50 or less; nearly 17 per cent, $50 to $100; and about 13 per cent, $100 to $200. Payment on behalf of 7 per cent of families ranged from $200 to $500, and, for less than one per cent, exceeded $500.

Of the 977 Saskatchewan physicians who provided at least one service for which the Commission made payment, 700 were general practitioners and 277 specialists.

Of the 4,650,300 individual services for which payment was made, 20.7 per cent were provided by specialists and 79.3 per cent by general practitioners. Payments to specialists amounted to 37.4 per cent of the total and payments to general practitioners, to 62.6 per cent. The overall average payment per service was $4.65 for male patients and $4.87 for female patients.

Age groups having the highest incidence of service were infants under 1 year and persons over 65, although the average payments per service in these age groups were below the average.

Children 5 - 14 received fewer services per capita than any other tabulated age group. Males showed a decline per unit cost of from $4.76 in 1964 to $4.65 in 1966, or a decrease of 2.5 per cent. In the case of females there was a decrease of 5.5 per cent between 1964 and 1966, i.e., from $5.15 to $4.87.

Forty per cent of all services were initial or repeat office visits. Another 23 per cent were hospital visits and an additional 6.5 per cent home and emergency calls. Altogether, home, office, and hospital visits represented 70 per cent of all services and 46.5 per cent of insurance payments. Diagnostic and laboratory tests accounted for 19.7 per cent of all services and 12.2 per cent of payments.

General practitioners made 85 per cent of home, office, and hospital calls and specialists 15 per cent. Such itemized procedures and services as major surgery, minor surgery, anaesthesia, obstetrics, and the services of surgical assistants made up 5.3 per cent of all items rendered but accounted for 33 per cent of payments. General practitioners provided 66 per cent of surgical services, obstetrical services, anaesthetist services and surgical assistance and specialists the remaining 34 per cent. Payments, however, were divided 50 per cent to general practitioners and 50 per cent to specialists.

Alberta - The Alberta Medical Plan was introduced in October 1963. It provided for public regulation of approved voluntary plans with regard to minimum benefits and maximum premiums and was primarily designed to help residents having poor health or low income to purchase voluntary medical care insurance from approved non-profit and commercial agencies. It was required that the benefits provided be comprehensive and that there could be no exclusions because of age, pre-existing health conditions, or a previous record of high utilization.

The plan was financed from personal premiums alone. The government contributed, as a subsidy, 80 per cent of the premium for persons with no taxable income, 50 per cent for persons with annual taxable incomes from $1 to $500, and 25 per cent for persons with annual taxable incomes from $501 to $1,000.

On July 1st, 1966, this plan was supplemented by an extended health-benefit plan which, for an additional premium, made available many other benefits including prescribed drugs, optometry, physiotherapy, ambulance service, osteopathy, chiropractic, podiatry, naturopathy, and certain other medical supplies and appliances. A deductible amount, co-insurance charges, and limited liability on some services applied to the extended plan.

On July 1st, 1967, these plans were superseded by the Alberta Health Plan, operated by the Department of Health for all residents voluntarily seeking individual or family enrolment. Group contracts are not available through this plan. In these respects the plan is similar to the plans in Ontario and British Columbia. The new Alberta plan is divided into two parts, Basic Health Services and Optional Health Services; the latter is further subdivided into Option A, Option B, and Option C. Any subscriber to the Basic Plan is eligible to contract for additional benefits, by paying additional premiums, under any one or more of the of the Options.

The Basic Plan covers all services of physicians, including health examinations, with payment of 100 per cent of the tariff; special dental surgery; limited optometric services; and podiatric and osteopathic services up to $100 annually. Option A offers as additional benefits certain hospital and ambulance services that are not already insured under the provincial hospital plan. These additional benefits include the hospital admission charge, the daily co-insurance charge in a standard ward (limited to 180 days per year in a chronic hospital), the differential charge when a semi-private room is occupied, hospital out-patient charges remaining due after appropriate government credits have been used, and ambulance benefits up to $100 per year. Option B covers 80 per cent of the cost of prescribed drugs and prosthetic appliances. The subscriber pays 20 per cent. Purchase and repair of artificial limbs, eyes, and braces, prescribed by a physician, are also covered up to $300 per year. Option C offers chiropractic and naturopathic services, up to $100 per year.

Premium rates for the Basic Plan are $60 per year for single persons, $120 for families of two persons, and $160 for families of three or more. Each Option costs an additional $12, $24 or $36 per year depending upon the number of persons. For individuals or families with little or no taxable income, premiums both for the Basic Plan and the Options may be reduced, by means of contributions from the general revenues of the province. These premium reductions vary from 90 per cent to 66 per cent for the Basic Plan, and are 66 per cent for the Options. They apply to single persons with less than $500 taxable income, and to families with under $1,000 taxable income in the previous year.

British Columbia - The British Columbia medical plan took effect in September 1965. As of mid-1967 it was administered by an agency directed by representatives of government and the medical profession. The benefits included most physicians' services as well as limited physiotherapy, special nursing, chiropractic and naturopathy. For eligible residents, the government offered subsidies totalling 90 per cent of the premium for persons with no taxable income and 50 per cent of the premium for persons with taxable income from $1 to $1,000. In addition, the government established a medical grant stabilization fund, initially of $2 million, to cover possible deficits.

Ontario - The Ontario medical services insurance plan began paying benefits in July 1966. The plan offered to all eligible Ontario residents, on an individual and family enrolment basis, an insurance plan that covered most physicians' services.

The government paid, as a subsidy, the full premium of applicants who had had no taxable income during the preceding year, and of recipients of public assistance. It paid 50 per cent of the premium for single applicants who had taxable income of $500 or less; 50 per cent of the premium for families of two persons and with taxable income of $1,000 or less; and 60 per cent of the premium for families of three or more persons and with taxable income of $1,300 or less.

Health care programs for welfare recipients under the Canada Assistance Plan. For several years Nova Scotia, Ontario, Manitoba, Alberta, and British Columbia have financed most of the cost of providing certain personal health care services under programs for welfare recipients in specified categories. In Newfoundland the basis of eligibility was certification by area welfare officers of the need for specific services.

During the last three or four years the trend has been to eliminate categorical status-e.g., age, disability, blindness, unemployment - as the basis of eligibility and to shift the emphasis towards tests of need applied to specific individuals and families who find themselves unable to pay for services or to purchase insurance. Such tests are based not solely on income or means but take into account, as well, his minimum living requirements.

Enactment of the Canada Assistance Plan in 1966 resulted in the expansion of many existing provincial programs and the introduction of legislation in other provinces such that, in the development of their programs, they would benefit from the cost-sharing provisions of the Plan (these provisions were retroactively effective to April 1, 1966). By mid-1967, programs involving payment to physicians were in operation in all provinces. Some also covered dentists, pharmacists, optometrists, and others. In Ontario, Saskatchewan, and Alberta, physicians' care benefits are administered through the separate public medical care schemes set up in these provinces. In other provinces the departmental agency (welfare or health) administering the overall health services program for welfare recipients continued to maintain responsibility for paying physicians as well as other suppliers of services.

The range of physicians' services covered in the benefits is usually comprehensive and includes medical visits in the home, office, and hospital, and surgery, diagnostic services, and obstetrical care. There are virtually no restrictions as regards medically-required care and no limitations arising from pre-existing conditions nor extra charges imposed on patients at time of receiving medical service. Other benefits that may be available, in addition to those already mentioned, include appliances, physiotherapy, special duty nursing, chiropody, medically-required transportation, eye glasses and other aids, chiropractic, and home nursing. Typically, where these are benefits, restrictions related to misuse or overuse are imposed through such devices as waiting periods, prior authorizations, or charges.

Subsection 5 - Services for the Disabled and the Chronically Ill

The success of rehabilitation programs for injured workers, war veterans, handicapped children, and other disability groups has encouraged more recent efforts to extend rehabilitation services to all handicapped persons. Physical medicine and rehabilitation departments have been established in the teaching hospitals and most veterans' and children's hospitals. There are about 40 children's hospitals and rehabilitation centres in the main cities.

Many children are also treated at general hospitals, or at 17 rehabilitation centres, which serve both adults and children. An additional four rehabilitation centres are operated under Workmen's Compensation programs.

Hospital services available to in-patients and out-patients include physical medicine, physiotherapy, occupational therapy, and social services; most of the children's hospitals and the teaching hospitals also supply speech therapy. The rehabilitation centres provide comprehensive medical, psychosocial, and vocational services to more-severely disabled persons who require intensive or long-term therapy. In addition, the children's hospitals and rehabilitation centres operate special education classes. Provincial and community agencies such as those providing vocational rehabilitation and home care services co-operate in the rehabilitation of disabled children and adults.

Most large general hospitals conduct special out-patient clinics for disabilities including arthritis and rheumatism, diabetes, glaucoma, speech and hearing defects, heart diseases and orthopedic and neurological conditions. Voluntary agencies, which are concerned with specific disability groups such as arthritics, the blind, the deaf, children suffering from cystic fibrosis, haemophilia, or muscular dystrophy, the mentally ill or retarded, or disabled persons generally, are also broadening their rehabilitation services. These agencies provide counselling, personal aids and appliances, transportation, employment and education,and sheltered workshops and also participate in the provision of services for the homebound. Organized home care programs, under either hospital or community sponsorship, initially established in the principal cities are now available in several rural counties. These are providing nursing, homemaker, physiotherapy and other services to the disabled, the chronically ill, the aged, and the convalescent, in their own homes. Several provincial health departments have instituted home nursing services to residents of outlying districts.

Provincial health, welfare, and education departments and voluntary agencies are developing specialized services for physically and mentally handicapped children. Most provinces have established registries of handicapped children, of varying coverage, in co-operation with physicians, health

units, hospitals, and other agencies. Such registries, which are increasingly useful sources of morbidity statistics including data on congenital anomalies, assist in the planning and co-ordination of rehabilitation services. In addition to medical rehabilitation, health departments and the crippled children's societies provide family counselling, recreation, transportation, and foster home care; travelling clinics extend periodic diagnostic and treatment services to outlying areas. Special schools or classes for various groups of handicapped children are established by local school boards in the main cities, but most of the 13 residential schools for the deaf and the six for the blind are operated under provincial auspices.

The establishment of three regional prosthetic research and training units in rehabilitation centres in Montreal, Toronto, and Winnipeg and of the Bio-Engineering Institute of the University of New Brunswick, supported by National Health Grants, are significant developments. The transfer of prosthetic services for veterans to the Department of National Health and Welfare on January 1, 1966, has made it possible for the provinces to extend prosthetic services to non-veterans. Artificial limbs and prosthetic appliances are made available through the Prosthetic Services in 12 Prosthetic Centres across Canada in accordance with provisions determined by provincial health departments. A federal-provincial program assists in meeting the extraordinary costs of rehabilitation, maintenance, and counselling on behalf of children with thalidomide-induced defects.

Services for the disabled and chronically ill are hampered by a shortage of qualified personnel, especially in the para-medical fields. Helping to solve this shortage are the ten university schools offering training in physical therapy and/or occupational therapy and the three providing training in audiology and speech therapy.

The Department of National Health and Welfare assists the provinces in their rehabilitation programs through the General Health Grants; in the year 1966-1967 a total of $40,407,080 was available. Of this $2,885,550 were specifically allocated to the Medical Rehabilitation and Crippled Children Grant. These grants are used to develop medical rehabilitation personnel through grants to the university schools and student bursaries, for equipment, and for research.

Section 4 - International Health

Canada actively assists and co-operates with the World Health Organization (WHO) and the other specialized agencies of the United Nations whose programs have a substantial health component or orientation. Capital and technical assistance are provided to developing countries through the Colombo Plan and other bilateral aid programs. Health training is provided for a number of persons coming to Canada each year under the different technical co-operation schemes;during 1966, 133 trainees arrived, bringing the total number of trainees in Canada during the year to 326. These persons were studying in a wide range of health disciplines under the External Aid Program, but with greatest concentration in undergraduate medicine and in public health.

Canadian experts in health legislation, health administration, nursing, and related areas undertook specific assignments abroad during the year and teachers and specialists in a number of clinical fields were provided in response to requests from developing countries. Capital assistance, primarily through the provision of cobalt beam therapy units for cancer treatment centres in the Colombo Plan area, was continued. A special feature during the year was the provision of over 600,000 doses of oral polio vaccine for a campaign amongst children in Saigon, Viet Nam.

Canada's membership on the Executive Board of UNICEF was renewed at the beginning of 1965. The Deputy Minister of National Welfare, Canada's representative on the Board, was elected Chairman for the period from February 1966 to July 1968.

To carry out Canada's obligations under the International Sanitary Conventions, the Department of National Health and Welfare maintains quarantine measures for ships and aircraft entering Canadian ports and provides accommodation and necessary medical care for persons arriving in Canada who require quarantine (see p. 9).

The Department is responsible for the enforcement of regulations governing the handling and shipping of shellfish under the International Shellfish Agreement between

Canada and the United States and, at the request of the International Joint Commission, participates in studies connected with control of pollution of boundary waters between Canada and the United States as well as with problems caused by atmospheric pollution. Other international health responsibilities include the custody and distribution of biological, vitamin, and hormone standards for WHO and certain duties in connection with the Single Convention on Narcotic Drugs, 1961, as well as Canada's representation on the Narcotic Commission of the United Nations.

PART II - PUBLIC WELFARE AND SOCIAL SECURITY

Responsibility for social welfare is shared by all levels of government. Comprehensive income-maintenance measures such as the Canada Pension Plan, old age security pensions, family allowances, youth allowances, and unemployment insurance, where nation-wide co-ordination is required, are administered federally. The federal government gives substantial aid to the provinces in meeting the costs of public assistance and also provides services for special groups such as veterans, Indians, Eskimos, and immigrants. The Department of National Health and Welfare is generally responsible for federal welfare matters although the Departments of Veterans Affairs, Indian Affairs and Northern Development, and Manpower and Immigration operate programs for specific groups.

Administration of welfare services is primarily the responsibility of the provinces but the provision of services is often assumed by local authorities, generally with financial aid from the province.

Section 1 - Federal Welfare Programs

Subsection 1 - Canada Pension Plan

The Act establishing the Canada Pension Plan received Royal Assent on April 3rd, 1965 and was proclaimed in force on May 5th of the same year. The collection of contributions commenced in January, 1966, and in January, 1967, the first benefits were paid in the form of Retirement Pensions.

The Plan represents an important milestone in Canadian social development. It will enable millions of people to make financial provision for their retirement and to protect themselves and their dependants or survivors against loss of income in the event of the disability or death of the head of the family.

The Plan is universally applicable throughout Canada,

except in the Province of Quebec where a comparable pension plan has been established. The Canada and Quebec Pension Plans, however, are closely co-ordinated and operate virtually as a single program. Together, they cover almost all members of the labour force in Canada.

Benefit credits accrued under the Canada or Quebec Plans are portable throughout Canada. A contributor who may have worked for more than one employer during his lifetime or who may be self-employed for all or part of his working life will accumulate pension credits regardless of where he may work in Canada. In addition, benefits under the Plan are payable to beneficiaries whether or not they live in Canada.

Every contributor to the Plan must have a Social Insurance Number so that his pensionable earnings may be accurately recorded for benefit purposes.

To participate in the Plan, a person must be between the ages of 18 and 70 and earn more than $600 yearly as an employee, or at least $800 if he is self-employed. As of 1967, contributions are made on earnings between $600 and $5,000 a year in the case of both employees and self-employed persons. Employees contribute at the rate of 1.8 per cent, with a matching contribution being made by their employers, while self-employed persons contribute at the rate of 3.6 per cent. No contributions are to be made by persons while they are receiving disability pensions.

Although contributions are made on annual earnings between $600 and $5,000, benefits are calculated on total earnings up to the maximum of $5,000. That is, while contributions are not paid on the first $600 of annual earnings, that amount is nevertheless included in the calculation of benefits.

Benefits are classified under three main headings: Retirement Pensions; Disability Pensions for contributors, with additional benefits for their dependent children; and Survivors' Benefits, consisting of a widow's pension, a disabled widower's pension, orphans' benefits, and a lump sum death benefit.

In 1967, Retirement Pensions became payable to contributors who were 68 years of age or over provided that, if under age 70, they were retired from regular employment. The minimum pensionable age is being reduced one year at a time until, commencing in 1970, Retirement Pensions will be payable to contributors who have retired from regular employment at the age of 65. In the case of contributors who have reached 70 years of age, Retirement Pensions are payable regardless of whether they are retired.

Retirement Pensions become payable at their full rates beginning in January, 1976. These rates amount to 25 per cent of what the up-dated pensionable earnings of contributors have averaged since January 1, 1966, or from age 18, whichever comes later.

Contributors who become eligible for Retirement Pensions prior to 1976 receive reduced amounts. In the calculation of Retirement Pensions which commence during this period, pensionable earnings are averaged over ten years or 120 months. The only exception to this rule is where a Disability Pension has been paid, in which case the time during which that pension was in pay is deducted from the ten years, and the remaining period is then used for averaging purposes.

In the calculation of Retirement Pensions which commence after 1975, provision is made to assist the contributor who for a variety of reasons may have had periods of low or no earnings during his contributory period. This is accomplished by dropping out the number of months during which contributions may have been made after age 65, and by either using the pensionable earnings in those months in place of earlier periods of lesser or no earnings, or by dropping such pensionable earnings out of the calculation if they are less favourable to him. Also dropped out of the calculation are up to 15 per cent of the number of months he could have contributed before age 65 and the earnings in an equal number of months. In this latter case, however, the drop-out must not reduce the number of months for averaging purposes to less than 120.

A person under 70 years of age who is in receipt of a Retirement Pension must meet an earnings test. In 1967, the maximum annual remuneration from employment which he may earn without affecting the amount of his pension is $900.

Should his yearly earnings exceed this figure, his pension is reduced as follows: when employment earnings are between $900 and $1,500, the reduction in pension will equal 50 per cent of the amount over $900, or an amount of up to $300 per year; if earnings exceed $1,500, the amount to be deducted will be $300, plus the actual amount that is earned over $1,500. However, the amount of his pension is not subject to reduction for any month in which the pensioner does not earn over $75. At age 70, a contributor is entitled to receive the full amount of his Retirement Pension regardless of the amount of his earnings.

Disability Pensions become payable in May, 1970. A contributor is considered to be disabled if he has a physical or mental disability that is so severe and likely to continue so long that he cannot engage in steady work. This will be determined by an assessment of the contributor's disability and employability. Disability Pensions, plus benefits for the dependent children of disabled contributors, will be available provided contributions have been made to the Plan for the required minimum period, namely, for five years if a Disability Pension is to commence before 1976.

The amount of the Disability Pension consists of a flat-rate payment calculated by multiplying $25* by the ratio that the Pension Index for the year in which the pension commences bears to the Pension Index for the year 1967, plus 75 per cent of what the contributor's monthly Retirement Pension would have been had he reached age 65 when his Disability Pension commenced. Benefits payable on behalf of a disabled contributor's dependent children consist of an amount equal to the flat-rate payment, mentioned above, for each of the first four children and one-half that amount for each additional child. Benefits are payable until the child reaches age 18, or up to the age of 25 years if he continues to attend school or university full time.

Survivors' Benefits become payable in February 1968. They will be paid to or on behalf of the survivors of a deceased contributor who has made contributions for the minimum qualifying period, namely, three years for benefits commencing before 1975.

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*This figure is subject to adjustment (see Page 57).

A woman who is widowed between ages 45 and 65 is entitled to a Widow's Pension consisting of the flat-rate payment, previously mentioned, plus 37 1/2 per cent of her husband's Retirement Pension. Should her husband not be in receipt of a Retirement Pension at the time of his death, such a pension is calculated in prescribed manner for the purposes of computing the amount of the Widow's Pension. If a woman is widowed under age 45, the same pension is paid provided she has dependent or disabled children or is herself disabled. If she does not meet any of these requirements, her pension is reduced by an amount equal to 1/120 for each month she is less than age 45 at the time of her husband's death. Accordingly, if a woman is widowed at age 35 or less, and has no dependent or disabled children and is not herself disabled, she will not receive a Widow's Pension until she reaches 65 years of age, unless she becomes disabled in the meantime.

A widow age 65 or over receives a Widow's Pension equal to 60 per cent of her husband's Retirement Pension. This is true for a widow regardless of her age at the time her husband died or whether she was receiving a Widow's Pension before she became 65. Again, if her husband was not in receipt of a Retirement Pension at the time of his death, one is calculated in prescribed manner in order to compute the amount of the Widow's Pension.

Women who receive Widow's Pensions may also have contributed to the Canada Pension Plan themselves and consequently may be entitled to Retirement or Disability Pensions in their own right. In such cases, the Widow's Pension will be combined with the other pension, in accordance with a prescribed formula, but the combined total cannot exceed the maximum Retirement Pension payable under the Act.

Orphans' Benefits are payable on behalf of a deceased contributor's dependent children. The rates are the same as the benefits for the children of a disabled contributor.

A Disabled Widower's Pension is payable where a widower is disabled and is wholly or substantially dependent on his wife for financial support at the time of her death. The test of disability is the same as that for a person who claims a Disability Pension and the pension formula is the same as that for a disabled widow.

When a contributor dies, a lump sum Death Benefit equal to six times his monthly Retirement Pension will be paid to his estate. This benefit is subject to a maximum of 10 per cent of the maximum on pensionable earnings which, in 1967, would mean a payment not exceeding $500. Should a contributor not be in receipt of a Retirement Pension at the time of his death, a calculation is made in prescribed manner for purposes of establishing the amount of the Death Benefit.

The Plan provides for the periodic adjustment of a number of its basic components. The maximum on pensionable earnings for 1966 and 1967 was set at $5,000 a year. Until 1976, this maximum is to be adjusted in line with changes in the Pension Index which, in turn, is based on the Consumer Price Index. Beginning in 1976, the maximum on pensionable earnings will be adjusted in accordance with changes in the Earnings Index which will reflect changes in average wage and salary levels in Canada.

The earnings-related component of the benefit which a person is entitled to receive under the Canada Pension Plan is based on the contributor's average pensionable earnings. Before this average is calculated, however, all earnings are adjusted in line with the applicable maximum on pensionable earnings during the benefit year. Thus, when a benefit first becomes payable, the earnings on which it is based are related to the maximum on pensionable earnings at that time rather than to the maximum when the earnings were received. The flat-rate components of Disability, Widows' and Disabled Widowers' Pensions, as well as the flat-rate benefits payable to the dependent children of disabled or deceased contributors, are also subject to adjustment by the Pension Index before going into pay. After benefits become payable, the amounts will be subject to periodic up-dating in accordance with increases in the Pension Index.

Any contributor or beneficiary under the Plan has the right to appeal decisions with which he is dissatisfied. Appeals by employees and employers regarding coverage and contributions are first made to the Minister of National Revenue and, if the individual is not satisfied with the Minister's decision, he may then appeal to the Pension Appeals Board whose decision is final.

For self-employed persons, appeals with reference to the assessment of their earnings for Canada Pension Plan purposes are treated in the same way as appeals under the Income Tax Act.

With respect to benefits, there is a three-stage appeal procedure; in the first place, to the Minister of National Health and Welfare; secondly, to a Review Committee; and thirdly, to the Pension Appeals Board whose decision is final.

The legislation provides for the investment of the funds that accrue from monthly contributions, less the estimated amounts required to pay benefits and administrative costs over a three-month period. These funds are made available to each province on the basis of the relationship between the contributions made to the Plan by and on behalf of residents of that province and the total contributions made to the Plan. Funds not borrowed by the provinces are invested in federal securities.

All benefits and all costs incurred in the administration of the program are financed solely from the contributions made by employees, employers and self-employed persons and the interest earned from the investment of funds. In other words, the Canada Pension Plan is entirely self-supporting.

Provision has been made for the establishment of an Advisory Committee representing employers, employees, self-employed persons and the public. This Committee is to review, from time to time, the overall operations of the Plan, the state of the Investment Fund, and the adequacy of coverage and benefits. The reports of the Committee are to be made to the Minister of National Health and Welfare and are to be included in the Annual Reports on the Plan.

Authority is also provided for the purpose of entering into arrangements with other countries to achieve as full coverage of persons in the labour force in Canada as is possible and to ensure the portability of pension credits between Canada and the countries concerned.

Subsection 2 - Old Age Security

Under the Old Age Security Act of 1951, as amended, the Federal Government pays a monthly pension to all persons who meet the necessary residence and age qualifications. Prior to 1966, the pension was payable to those age 70 or over but in 1966 a reduction in pensionable age from 70 to 65, to be completed over a five-year period, was begun. By 1967, the pension was payable to qualified persons age 68 and over and is payable to those age 67 and over in 1968, to those age 66 and over in 1969 and, from 1970 on, to those 65 years of age and over. Until 1967, the pension amounted to $75 a month but, in 1968 and succeeding years, the amount of the pension may be adjusted in line with changes in the Pension Index developed for the Canada Pension Plan (see p. 57).

The old age security pension is payable to a person of attained age who has resided in Canada for ten years immediately preceding the approval of his application for the pension. Any gaps in the ten-year period may be offset if the applicant had resided in Canada in earlier years for periods of time equal in total to double the length of the gaps; in this case, however, the applicant must also have resided in Canada for one year immediately before his application for pension. The pension is also payable to persons of attained age who have left Canada before reaching that age but who have had 40 years of residence in Canada since age 18. A pensioner may absent himself from Canada and continue to receive payments. If he has lived in Canada for 25 years since his 21st birthday, payment outside of Canada may continue indefinitely; if not, payment is continued for six months, in addition to the month of departure, and is then suspended, to be resumed only with the month in which he returns to Canada.

The program is administered by the Department of National Health and Welfare through regional offices located in each provincial capital, to which application is made for pension. It is financed through a 3-p.c. sales tax, a 3-p.c. tax on corporation income and, subject to a limit of $240 a year, a 4-p.c. tax on taxable personal income.

The revenues from these sources are paid into a separate fund called the Old Age Security Fund, from which are paid the Old Age Security pensions and, from January 1,1967, benefits under the Guaranteed Income Supplement program (see below).

Guaranteed Income Supplement.- An amendment to the Old Age Security Act approved in December 1966, provides for the payment of a monthly guaranteed income supplement to Old Age Security pensioners who have little or no income other than the pension. The Guaranteed Income Supplement is limited to pensioners born on or before December 31, 1910, who by reasons of age are or will be unable to benefit substantially from the Canada or Quebec Pension Plans. The program commenced on January 1, 1967.

Pensioners with only the old age security pension will receive a guaranteed annual income of $1,260 for a single pensioner and, for a married couple who are both pensioners, $2,520. This consists of the $75 a month pension and the monthly supplement of $30, which is subject to an income test. Pensioners with income in addition to their old age security pension may receive partial benefits. The maximum supplement payable beginning in January, 1967, is $30 per month. In any year after 1967, it is to be 40 per cent of the amount of the flat-rate Old Age Security pension.

The maximum supplement is reduced by $1 per month for every full $2 per month of income over and above the Old Age Security pension. Income for this purpose is the same as that computed in accordance with the Income Tax Act. In the case of a married couple, each is considered to have one-half of their combined income. Where one spouse will not be receiving an Old Age Security pension at any time in the current year, to make allowance for that fact $450 is deducted from one-half of the combined income in calculating the income of the pensioner for Guaranteed Income Supplement purposes.

Payments will not be made to married couples unless both spouses submit returns. However, in order to prevent undue hardship when no statement of income is obtainable a person may be deemed to be single for purposes of determining income. Furthermore, although marital

TABLE 12 - OPERATIONS OF THE OLD AGE SECURITY FUND, YEARS ENDED MARCH 31, 1961 TO 1967

Item	1960-61	1961-62	1962-63	1963-64	1964-65	1965-66	1966-67
	$	$	$	$	$	$	$
Source of funds:							
Sales tax	270,231,478	284,879,239	302,238,927	331,760,067	383,151,254	522,085,844	559,515,046
Corporation income tax	103,500,000	100,125,000	115,250,000	115,750,000	145,250,000	152,250,000	149,500,000
Individual income tax	229,400,000	258,950,000	273,650,000	302,600,000	431,900,000	494,900,000	576,600,000
Loan from consolidated revenue fund	-	-	41,679,066	58,281,233	-	-	-
Balance brought forward	-	-	1,563,639	-	-	-	216,982,842
Total	603,131,478	643,954,239	734,381,632	808,391,300	960,301,254	1,169,235,844	1,502,597,888
Application of funds:							
Benefit payments	592,413,253	625,107,204	734,381,632	808,391,300	935,294,468	994,239,487	1,073,005,708(1)
Repayment of loans to consolidated revenue fund	10,718,105	17,282,796	-	-	75,006,786	24,953,515	-
Balance carried over	-	1,563,639	-	-	-	216,982,842	429,592,180
Total	603,131,478	643,954,239	734,381,632	808,391,300	960,301,254	1,169,235,844	1,502,597,888

(1) Includes $[illegible] under the Old Age Security program and $30,597,478 in Guaranteed Income Supplement payments, [illegible].

TABLE 13 - OLD AGE SECURITY STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1967

Province and year	Pensioners in March	Net pensions paid during fiscal year	Province and year	Pensioners in March	Net pensions paid during fiscal year
	No.	$		No.	$
Newfoundland 1963	18,184	14,013,832	Manitoba 1963	57,692	44,617,405
1964	18,477	15,376,636	1964	58,850	48,874,928
1965	18,886	16,811,166	1965	59,818	53,360,235
1966	21,184	17,586,159	1966	65,758	55,494,509
1967	23,733	19,706,767	1967	71,471	60,767,093
Prince Edward Island 1963	7,635	5,962,922	Saskatchewan 1963	59,690	46,334,646
1964	7,794	6,493,258	1964	60,587	50,751,907
1965	7,949	7,118,615	1965	61,257	55,063,268
1966	8,809	7,447,170	1966	66,638	56,755,191
1967	9,665	8,207,258	1967	71,892	61,478,838
Nova Scotia 1963	43,583	33,817,492	Alberta 1963	64,286	49,787,140
1964	44,424	37,063,710	1964	65,746	54,835,096
1965	45,014	40,399,804	1965	67,245	60,052,938
1966	49,801	42,048,599	1966	74,514	62,793,976
1967	54,690	46,533,160	1967	82,145	69,524,557
New Brunswick 1963	31,935	24,858,331	British Columbia 1963	120,678	93,362,860
1964	32,592	27,247,749	1964	122,732	102,639,328
1965	33,262	29,780,719	1965	124,262	111,327,361
1966	36,852	30,994,768	1966	135,556	115,292,880
1967	40,565	34,358,253	1967	147,930	125,662,029
Quebec 1963	202,405	155,359,915	Yukon and Northwest Territories 1963	676	524,445
1964	207,917	171,996,794	1964	680	564,696
1965	214,294	189,682,327	1965	707	633,415
1966	242,865	201,031,156	1966	802	660,570
1967	275,515	228,797,146	1967	886	744,905
Ontario 1963	344,002	265,742,644	Canada 1963	950,766	734,381,632
1964	352,004	292,547,198	1964	971,801	808,391,300
1965	360,888	321,064,620	1965	993,582	885,294,468
1966	402,997	337,194,513	1966	1,105,776	927,299,487
1967	451,069	377,628,224	1967	1,229,561	1,033,408,230

status is determined as at December 31 of the preceding year, even if this status should change in the current year, a special provision allows a person to be deemed either married or single in the preceding year.

Entitlement to a supplement is normally based on the pensioner's income in the previous year. However, where a pensioner retired from employment or self-employment in that year or in the current year, he may elect to substitute estimates of certain income items (such as employment earnings and pensions) in the current year for that which he actually received in the preceding year. This may allow him to show a lower income and hence to become eligible for a higher supplement.

If a pensioner who is in receipt of a supplement leaves Canada, the supplement will be paid for the month of departure and for six further months. If he has not returned by then, payment will be discontinued but may be paid again upon his return. If on the date when a supplement might otherwise become payable to a pensioner he has been absent from Canada for six months, no supplement may be paid until his return. If his absence has been for less than six months, a supplement may be paid until he has been away for six months. It will then be discontinued until his return.

The Guaranteed Income Supplement program is administered in conjuction with the Old Age Security pension program. An application for the supplement is sent to each person when he begins to recieve the Old Age Security pension and subsequently at the beginning of each calendar year. Entitlement is reassessed each year on the basis of the pensioner's income in the preceding year.

TABLE 14 - GUARANTEED INCOME SUPPLEMENT STATISTICS, BY PROVINCE, PERIOD(1) ENDED MARCH 31, 1967

Province	Pensioners in March	Net Supplements Paid in Period
	No.	$
Newfoundland	18,037	1,520,404
Prince Edward Island	6,444	521,776
Nova Scotia	30,613	2,464,576
New Brunswick	21,937	1,795,836
Quebec	136,306	10,968,346
Ontario	128,639	9,761,469
Manitoba	35,633	2,731,259
Saskatchewan	33,132	2,545,612
Alberta	36,526	2,863,528
British Columbia	57,922	4,421,545
Yukon	26	1,343
Northwest Territories	25	1,784
Canada	505,240	39,597,478

(1) Three months; program commenced January 1, 1967.

Subsection 3 - Family Allowances

The Family Allowances Act of 1944 is designed to assist in providing equal opportunity for all Canadian children. The allowances do not involve a means test and are paid from the federal Consolidated Revenue Fund. They do not constitute taxable income but there is a smaller income tax exemption for children eligible for allowances. The province of Quebec introduced its own family allowances program, supplementing the federal scheme, under legislation enacted in 1967 (see p. 105).

Allowances are payable in respect of every child under the age of 16 years who was born in Canada, or who has been a resident of the country for one year, or whose father or mother was domiciled in Canada for three years immediately prior to the birth of the child. Payment is made by cheque each month, normally to the mother, although any person who substantially maintains the child may be paid the allowance on his behalf. Allowances are paid at the monthly rate of $6 for each child under 10 years of age and $8 for each child age 10 or over but under 16 years. If the allowances are not spent for the purposes outlined in the Act, payment may be discontinued or made to some other person or agency on behalf of the child. Allowances are not payable for any child who fails to comply with provincial school regulations or on behalf of a girl who is married and under 16 years of age.

The program is administered by the Department of National Health and Welfare through regional offices located in each provincial capital. The Regional Director located at Edmonton also administers the accounts of residents in the Yukon and Northwest Territories.

The federal government pays family assistance, at the rates applicable for family allowances, for each child under 16 years of age resident in Canada and supported by an immigrant who has landed for permanent residence in Canada, or by a Canadian returned to Canada to reside permanently. The assistance, which is payable monthly for the first year of the child's residence in Canada, is intended to bridge the gap until the child becomes eligible for family allowances.

TABLE 15 - FAMILY ALLOWANCES STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1967

Province and year	Families receiving allowance in March	Children for whom allowance paid in March	Average number of children per family in March	Average allowance (1)		Net total allowances paid during fiscal year
				Per family	Per child	
	No.	No.	No.	$	$	$
Newfoundland ... 1963	66,657	207,120	3.11	20.80	6.70	16,562,083
1964	67,635	209,180	3.09	20.75	6.71	16,747,021
1965	68,418	210,016	3.07	20.59	6.71	16,871,056
1966	69,346	210,512	3.04	20.40	6.71	16,945,059
1967	70,435	210,082	2.98	20.08	6.73	16,960,053
Prince Edward Island 1963	14,344	40,423	2.82	18.99	6.74	3,259,952
1964	14,377	40,524	2.82	19.05	6.76	3,274,057
1965	14,191	40,201	2.83	19.12	6.75	3,266,459
1966	14,054	39,632	2.82	19.03	6.75	3,231,716
1967	14,099	39,342	2.79	18.81	6.74	3,190,484
Nova Scotia 1963	106,018	271,476	2.56	17.14	6.69	21,838,772
1964	105,754	271,336	2.57	17.20	6.70	21,790,680
1965	105,163	269,845	2.57	17.24	6.72	21,776,091
1966	104,856	267,689	2.55	17.18	6.74	21,636,528
1967	105,214	264,998	2.52	17.01	6.75	21,507,992
New Brunswick .. 1963	83,272	239,507	2.87	19.33	6.72	19,340,514
1964	82,711	237,093	2.87	19.29	6.73	19,198,184
1965	82,578	235,714	2.85	19.24	6.74	19,069,036
1966	82,851	233,724	2.82	19.05	6.76	18,982,908
1967	82,929	229,798	2.77	18.76	6.77	18,752,034
Quebec 1963	752,413	1,999,894	2.66	17.87	6.72	160,299,079
1964	766,364	2,017,190	2.63	17.74	6.74	162,172,423
1965	780,305	2,037,605	2.61	17.60	6.74	163,888,091
1966	792,955	2,043,428	2.57	17.38	6.76	164,972,052
1967	805,315	2,034,966	2.53	17.10	6.77	165,095,827
Ontario 1963	939,314	2,172,643	2.31	15.44	6.68	172,711,354
1964	949,955	2,209,982	2.33	15.56	6.69	175,544,729
1965	964,468	2,248,642	2.33	15.65	6.71	179,056,316
1966	983,502	2,284,059	2.32	15.61	6.73	182,377,587
1967	1,007,038	2,308,919	2.29	15.48	6.75	185,309,485

(1) Based on gross payment for March.

TABLE 15 - FAMILY ALLOWANCES STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1967 (Concluded)

Province and year	Families receiving allowance in March	Children for whom allowance paid in March	Average number of children per family in March	Average allowance(1)		Net total allowances paid during fiscal year
				Per family	Per child	
	No.	No.	No	$	$	$
Manitoba 1963	132,937	319,564	2.40	16.07	6.69	25,523,719
1964	133,105	321,413	2.41	16.17	6.69	25,727,440
1965	133,500	323,862	2.43	16.24	6.69	25,926,570
1966	132,148	321,747	2.43	16.30	6.71	25,925,991
1967	131,011	315,166	2.41	16.26	6.76	25,651,443
Saskatchewan ... 1963	131,066	331,394	2.53	16.89	6.68	26,539,801
1964	131,240	333,051	2.53	16.97	6.69	26,650,259
1965	131,449	335,381	2.55	17.09	6.70	26,891,288
1966	131,266	332,952	2.54	17.11	6.74	26,988,369
1967	130,876	330,015	2.52	17.05	6.76	26,870,934
Alberta 1963	208,646	509,805	2.44	16.29	6.67	40,315,733
1964	211,105	519,140	2.46	16.47	6.70	41,227,721
1965	212,630	525,976	2.47	16.57	6.70	41,996,327
1966	213,489	525,859	2.46	16.58	6.74	42,345,742
1967	216,086	527,411	2.44	16.50	6.76	42,563,978
British Columbia 1963	239,496	550,380	2.30	15.40	6.70	43,834,184
1964	242,789	561,174	2.31	15.51	6.71	44,712,129
1965	247,635	573,714	2.32	15.58	6.73	45,745,199
1966	254,871	589,041	2.31	15.60	6.75	47,006,572
1967	264,480	605,443	2.29	15.50	6.77	48,525,782
Yukon and Northwest Territories ... 1963	6,582	17,674	2.68	17.03	6.34	1,341,158
1964	6,237	16,074	2.58	17.21	6.68	1,267,581
1965	6,212	16,057	2.58	17.19	6.65	1,288,798
1966	6,298	16,414	2.61	17.21	6.60	1,322,300
1967	6,458	16,734	2.59	17.84	6.88	1,366,935
Canada 1963	2,680,745	6,6[illegible],820	2.48	16.63	6.69	531,566,349
1964	2,711,272	6,736,157	2.48	16.67	6.71	538,312,224
1965	2,746,549	6,817,013	2.48	16.68	6.72	545,775,231
1966	2,785,636	6,865,057	2.46	16.59	6.74	551,734,824
1967	2,833,941	6,882,874	2.43	16.42	6.76	555,794,947

(1) Based on gross payment for March.

Subsection 4 - Youth Allowances

Legislation providing for a program of youth allowances became effective September 1, 1964. The federal government does not provide youth allowances in Quebec, which has had its own program since 1961, but that province is compensated by a tax abatement adjusted to equal the amount that the federal government would otherwise have paid in allowances to Quebec residents.

Under the federal program monthly allowances of $10 are payable in respect of all dependent youths age 16 and 17 who are receiving full-time educational training or are precluded from doing so by reason of physical or mental infirmity. Both the parent or guardian and the youth must normally be physically present and living in a province other than Quebec. The allowance is not payable to a parent who resides in Quebec or outside Canada, regardless of where his child may be attending school. However, a dependent youth may attend school in Quebec or outside Canada or, if disabled, receive care or training in Quebec or outside Canada, and still be considered eligible, on the basis that he is a resident of a province other than Quebec but is temporarily absent.

Allowances normally commence with the month following that in which family allowances cease and continue until the school year terminates. They are paid retroactively for the summer months when the youth returns to school at the commencement of the new school year. Allowances for a disabled child not attending school, however, are payable continuously throughout the year. Should the youth leave school, leave the country permanently, cease to be maintained, take up residence in Quebec, or die, the allowance will cease. Otherwise, the youth allowance continues until the end of the month in which the youth reaches age 18. Youth allowances are considered not to be income for any purpose of the Income Tax Act.

The program is administered by the Department of National Health and Welfare. The national director of the family allowances and old age security programs also administers youth allowances, assisted by regional directors

located in each of the provincial capitals other than Quebec City. The costs of youth allowances are met from the Consolidated Revenue Fund.

Section 2 - Federal-Provincial Welfare Programs

Subsection 1 - Canada Assistance Plan

The Canada Assistance Plan was enacted in 1966 as a comprehensive public assistance measure to complement other income security measures. It provides, under agreements with the provinces, federal contributions of 50 per cent of the costs of assistance to persons in need and of the costs of the welfare services described below.

The Canada Assistance Plan is designed to replace the Unemployment Assistance Act, 1956, although the latter will continue in effect in some provinces for an interim period with respect to certain programs that utilize a means test and are not covered under the Canada Assistance Plan. Under the terms of the Canada Assistance Plan legislation, the provinces may discontinue the receipt of applications under the programs of old age assistance, blind persons allowances and disabled persons allowances and provide instead aid under their general programs, with costs shared under the Canada Assistance Plan. All provinces had signed agreements under the Canada Assistance Plan by the end of August 1967. The arrangements for contracting out of certain shared-cost programs that were introduced in 1965 under the Established Programs (Interim Arrangements) Act are applied to Quebec's agreement under the Plan.

Effective from April 1, 1966, the Canada Assistance Plan extends federal sharing to include the following costs, which were not shared under the Unemployment Assistance Act: the cost of assistance to needy mothers with dependent children, maintenance of children in the care of provincially approved child welfare agencies, health care services to needy persons, and the extension of welfare services to prevent or remove causes of dependency or to assist recipients in achieving self-support. Health care services may include medical, surgical, obstetrical, optical, dental, and nursing

TABLE 16 - YOUTH ALLOWANCES STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1965 TO 1967

Province and Year		Youths for whom allowance paid in March			Net total allowance paid during fiscal year(1)
		Attending school full-time	Having physical or mental infirmity	Total youths	
		No.	No.	No.	$
Newfoundland	1965	13,673	125	13,798	881,777
	1966	14,970	151	15,121	1,591,901
	1967	15,527	157	15,684	1,686,661
Prince Edward Island	1965	3,391	44	3,435	231,142
	1966	3,553	40	3,593	395,465
	1967	3,432	38	3,470	397,505
Nova Scotia	1965	23,385	164	23,549	1,590,976
	1966	22,972	176	23,148	2,691,768
	1967	22,938	192	23,130	2,654,786
New Brunswick	1965	19,885	194	20,079	1,352,716
	1966	19,868	204	20,072	2,311,244
	1967	19,878	199	20,077	2,300,043
Ontario	1965	186,988	725	187,713	12,652,036
	1966	189,923	783	190,706	21,978,399
	1967	192,861	1,234	194,095	22,491,673
Manitoba	1965	28,017	106	28,123	1,916,217
	1966	27,930	148	28,078	3,249,490
	1967	27,775	134	27,909	3,242,828
Saskatchewan	1965	29,146	107	29,253	1,990,364
	1966	29,605	94	29,699	3,414,834
	1967	29,718	86	29,804	3,434,721
Alberta	1965	41,297	154	41,451	2,806,661
	1966	41,877	181	42,058	4,836,771
	1967	42,868	235	43,103	4,960,783
British Columbia	1965	50,002	137	50,139	3,415,086
	1966	51,556	214	51,770	5,934,292
	1967	54,039	252	54,291	6,159,249
Yukon	1965	258	-	258	17,060
	1966	258	1	259	30,210
	1967	243	1	244	28,044
Northwest Territories	1965	235	-	235	15,780
	1966	290	-	290	34,176
	1967	312	2	314	39,340
Total	1965	396,277	1,756	398,033	26,869,815
	1966	402,802	1,992	404,794	46,468,550
	1967	409,591	2,530	412,121	47,395,633

(1) 1965 figures cover seven months; program became effective September 1, 1964.

services; drugs; dressings; prosthetic appliances ; and other items associated with the provision of such services. Welfare services may include rehabilitation services; case work; counselling and assessment services; adoption services; and homemaker, day-care, and similar services supplied to persons in need or to persons to whom the service is essential if they are to remain self-supporting.

The only eligibility requirement specified in the Canada Assistance Plan is that of need, which is to be determined through an assessment of budgetary requirements as well as of income and resources. A province must not require previous residence as a condition of eligibility for assistance or for continued assistance. Rates of assistance and eligibility requirements are set by the province. The Plan thus enables the provinces to adjust their rates to local conditions and to take into account the needs of special groups. It requires that the provinces establish procedures for appeal from decisions that relate to the provision of assistance.

The federal government reimburses the provinces for 50 per cent of the cost of assistance provided to persons in need and for 50 per cent of certain costs of improving or extending welfare services.

"Assistance" includes any form of aid to or in behalf of persons in need for the purpose of providing basic requirements such as food, shelter, and clothing; items necessary for the safety, well-being, or rehabilitation of a person in need, such as special food or clothing, telephone, rehabilitation allowance, or items necessary for a handicapped person; care in a home for special care such as a home for the aged, a nursing home, or a welfare institution for children; travel and transportation; funerals and burials; health care services; welfare services purchased by or at the request of provincially approved agencies; and comfort allowances for inmates of institutions.

The cost of improving and extending welfare services may be calculated either (1) as the amount by which the cost of providing welfare services exceeds that of the period from April 1, 1964 to March 31, 1965 or (2) as the cost of employing persons who are engaged wholly or mainly in the performance of welfare service functions and who are employed

in positions filled after March 31, 1965. Included for sharable purposes are the costs of salaries and employee benefits, travel, research, consultation, fees for conferences and seminars, and certain costs of staff training whether incurred by the province or by the municipalities.

The sharing of costs of work activity projects that prepare persons for employment and of the extension of provincial welfare services to Indians on reserves, on Crown lands, or in unorganized territory, is governed by special agreements.

Subsection 2 - Unemployment Assistance

Under the Unemployment Assistance Act 1956, as amended, the federal government was authorized to enter into an agreement with any province to reimburse it for 50 per cent of the unemployment assistance expenditures made by the province and its municipalities to persons and their dependants who are unemployed and in need. Payments to both employable and unemployable persons are sharable, as are the costs of maintaining persons in homes for special care, such as nursing homes and homes for the aged, and the costs of supplementary aid to recipients of old age security pensions, old age assistance, blind persons allowances, disabled persons allowances and unemployment insurance benefits where the amount of assistance is determined on the basis of need. Federal sharing was extended to mothers' allowances from April 1, 1966.

Effective from April 1, 1965, Quebec received partial payment for assistance costs under the Established Programs (Interim Arrangements) Act under which the province is entitled to compensation in the form of a tax abatement and an equalization payment.

As noted above, all programs under which aid is based on a needs test will be included for reimbursement under the Canada Assistance Plan under which all provinces have signed agreements. The Unemployment Assistance Act, however, will remain in effect for a transitional period in some provinces to cover the costs of aid to residual groups of persons under certain means test programs during the process of conversion to needs test programs.

During the year ended March 31, 1966, the federal government made payments amounting to $100,394,324 for unemployment assistance.

Subsection 3 - Old Age Assistance

The Old Age Assistance Act of 1951, as amended, provides for federal reimbursement to the provinces for assistance to persons age 65 or over who are in need and who meet the ten years' residence and income requirements. For an unmarried person, total income allowed, including assistance, may not exceed $1,260 a year. For a married couple, it may not exceed $2,220 a year or, when the spouse is blind within the meaning of the Blind Persons' Act, $2,580 a year.

A pensioner is transferred to Old Age Security on reaching the eligible age for it (see p. 60). The federal contribution may not exceed 50 p.c. of $75 a month or of the assistance paid, whichever is less. The province administers the program and, within the limits of the federal Act, may fix the amount of assistance payable, the maximum income allowed and other conditions of eligibility. Effective April 1, 1965, Quebec withdrew from this federal-provincial program under the Established Programs (Interim Arrangements) Act, which entitles the province to a tax abatement and an equalization payment.

Under the terms of the Canada Assistance Plan a province may elect to aid needy persons over 65 years of age under a general assistance program with costs shared under the Canada Assistance Plan (see p. 69). In accordance with this provision several provinces no longer accept applications under the Old Age Assistance program. They may also transfer current recipients of old age assistance to their general programs, provided that there is no decrease in benefits. The provinces are gradually taking steps to alter their programs in this way.

TABLE 17 - UNEMPLOYMENT ASSISTANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1966

Province and year		Recipients(a) in March	Federal share of unemployment assistance costs(b)
		No.	$
Newfoundland	1963	59,199	4,218,132
	1964	59,090	4,565,680
	1965	58,931	4,620,079
	1966	51,604	4,484,744
Prince Edward Island ..	1963	3,270	261,242
	1964	2,924	292,832
	1965	2,628	306,525
	1966	2,914	337,825
Nova Scotia	1963	28,056	1,630,551
	1964	27,565	1,798,653
	1965	26,991	1,875,679
	1966	26,186	1,921,734
New Brunswick	1963	39,782	1,715,372
	1964	31,114	1,743,488
	1965	24,450	1,562,799
	1966	25,582	1,514,402
Quebec	1963	265,612	36,274,154
	1964	253,295	39,130,901
	1965	248,334	41,877,054
	1966	258,415	22,586,629(c)
Ontario	1963	141,068	20,447,510
	1964	140,066	24,350,089
	1965	135,347	25,812,190
	1966	134,824	28,318,276

(a) Includes dependents.
(b) Payment figures shown are for the months to which the claims made under the program relate and include amounts paid to the provinces by the federal government after the end of the fiscal year.
(c) During the year Quebec claims were reduced by the amount of $20,149,002 representing the federal welfare portion of cost for which compensation was provided in the form of a tax abatement.

TABLE 17 - UNEMPLOYMENT ASSISTANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1966 (Concluded)

Province and year		Recipients(a) in March	Federal share of unemployment assistance costs(b)
		No.	$
Manitoba	1963	32,579	4,526,994
	1964	31,282	4,952,050
	1965	31,446	5,203,784
	1966	30,806	5,718,057
Saskatchewan	1963	44,227	4,777,911
	1964	41,880	4,614,614
	1965	40,600	4,578,307
	1966	36,810	4,218,635
Alberta	1963	44,824	6,486,669
	1964	51,048	7,981,780
	1965	60,653	9,707,440
	1966	62,783	11,055,266
British Columbia	1963	94,570	15,798,279
	1964	93,763	16,918,569
	1965	92,192	17,177,860
	1966	93,904	20,104,665
Yukon	1963	292	52,496
	1964	352	67,392
	1965	322	71,509
	1966	309	71,577
Northwest Territories..	1963	685	62,849
	1964	1,110	81,926
	1965	1,179	96,672
	1966	1,338	62,514
Canada	1963	754,163	96,252,159
	1964	733,489	106,497,974
	1965	723,073	112,889,898
	1966	715,475	100,394,324

(a) Includes dependents.
(b) Payment figures shown are for the months to which the claims made under the program relate and include amounts paid to the provinces by the federal government after the end of the fiscal year.

TABLE 18 - OLD AGE ASSISTANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1967

Province and year		Recipients in March	Average amount of monthly assistance	Federal government contribution during year(a)
		No.	$	$
Newfoundland	1963	5,187	63.00	1,987,213
	1964	5,081	62.79	1,945,021
	1965	5,088	72.41	2,220,908
	1966	4,080	72.14	2,121,068
	1967	3,110	71.69	1,675,756
Prince Edward Island	1963	1,037	60.35	375,350
	1964	1,130	60.38	394,947
	1965	1,229	70.43	508,587
	1966	988	70.73	498,378
	1967	712	70.35	390,463
Nova Scotia	1963	5,421	59.76	2,007,871
	1964	5,509	69.11	2,084,088
	1965	5,574	68.53	2,302,860
	1966	4,423	67.96	2,188,257
	1967	3,134	68.39	1,667,068
New Brunswick	1963	5,491	61.58	2,065,950
	1964	5,447	70.96	2,121,388
	1965	5,356	70.28	2,303,178
	1966	4,200	69.72	2,161,779
	1967	3,033	70.06	1,620,148
Quebec	1963	37,086	61.48	13,793,745
	1964	38,206	60.96	13,860,075
	1965	39,239	70.35	16,589,045
	1966	(b)	(b)	(b)
	1967	(b)	(b)	(b)
Ontario	1963	23,925	58.80	8,458,293
	1964	25,197	67.59	9,134,698
	1965	26,049	67.03	10,465,257
	1966	19,991	67.28	10,006,001
	1967	13,279	67.04	7,238,584

(a) Maximum assistance sharable by the federal government was increased from $65 to $75 a month as of December 1963.

(b) Effective April 1, 1965, payments were made to Quebec under the Established Programs (Interim Arrangements) Act.

TABLE 18 - OLD AGE ASSISTANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1967 (Concluded)

Province and year		Recipients in March	Average amount of monthly assistance	Federal government contribution during year(a)
		No.	$	$
Manitoba	1963	5,448	60.83	2,001,606
	1964	5,436	70.06	2,105,940
	1965	5,520	69.15	2,329,362
	1966	4,241	69.02	2,188,141
	1967	2,956	68.73	1,611,858
Saskatchewan	1963	5,866	59.63	2,220,539
	1964	5,549	68.59	2,151,490
	1965	5,463	69.04	2,294,105
	1966	3,975	68.87	2,097,642
	1967	1,496	67.62	1,131,452
Alberta	1963	6,479	60.30	2,523,720
	1964	6,644	69.56	2,559,785
	1965	6,810	69.00	2,901,039
	1966	6,453	68.61	2,795,633
	1967	3,617	65.62	2,092,389
British Columbia	1963	7,039	62.26	2,675,207
	1964	6,864	72.01	2,781,892
	1965	6,829	71.82	2,991,013
	1966	5,478	71.74	2,836,336
	1967	4,074	72.18	2,252,115
Yukon	1963	34	64.47	15,287
	1964	31	65.00	12,113
	1965	31	75.00	13,880
	1966	26	75.00	13,553
	1967	15	74.73	8,826
Northwest Territories	1963	144	63.36	54,275
	1964	147	64.40	56,743
	1965	166	74.32	71,721
	1966	133	73.64	73,722
	1967	120	72.75	62,085
Canada	1963	103,159	60.68	38,179,057
	1964	105,241	65.72	39,208,181
	1965	107,354	69.43	44,990,955
	1966	52,988(b)	68.85(b)	26,980,510(b)
	1967	35,546(b)	68.52(b)	19,750,744(b)

(a) Maximum assistance sharable by the federal government was increased from $65 to $75 a month as of December 1963.

(b) Excludes Quebec.

Subsection 4 - Allowances for Blind Persons

The Blind Persons Act of 1951, as amended, provides for federal reimbursement to the provinces for allowances to blind persons age 18 or over who meet the ten years' residence and income requirements. For an unmarried person, total income including the allowance may not exceed $1,500 a year; for a person with no spouse but with one or more dependent children, $1,980; for a married couple, $2,580. When the spouse is also blind, income of the couple may not exceed $2,700.

The federal contribution may not exceed 75 per cent of $75 a month or of the allowance paid, whichever is less. The province administers the program and, within the limits of the federal Act, may fix the amount of allowance payable and the maximum income allowed. Effective April 1, 1965, Quebec withdrew from this federal-provincial program under the Established Programs (Interim Arrangements) Act, which entitles the province to a tax abatement and an equalization payment.

Under the terms of the Canada Assistance Plan a province may elect to aid needy blind persons under a general assistance program with costs shared under the Canada Assistance Plan (see p. 69). In accordance with this provision several provinces no longer accept applications under the Blind Persons Allowance Act. They may also transfer current recipients of blind persons allowances to their general programs, provided that there is no decrease in benefits. The provinces are gradually taking steps to alter their programs in this way.

TABLE 19 - BLINDNESS ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1967

Province and year		Recipients in March	Average amount of monthly allowance	Federal government contribution during year(a)
		No.	$	$
Newfoundland	1963	429	63.70	247,377
	1964	436	63.66	246,924
	1965	460	73.49	300,474
	1966	445	73.27	304,203
	1967	438	72.98	292,224
Prince Edward Island	1963	83	63.21	47,103
	1964	79	64.43	46,778
	1965	71	73.47	51,020
	1966	72	72.92	47,372
	1967	67	72.92	46,142
Nova Scotia	1963	792	63.08	450,275
	1964	775	73.00	468,866
	1965	750	73.41	509,671
	1966	714	72.72	487,504
	1967	682	73.19	466,060
New Brunswick	1963	701	63.79	410,317
	1964	679	73.77	418,037
	1965	679	74.10	456,965
	1966	626	73.35	438,437
	1967	589	73.44	407,930
Quebec	1963	2,891	63.74	1,662,937
	1964	2,855	63.65	1,642,869
	1965	2,843	73.47	1,892,813
	1966	(b)	(b)	(b)
	1967	(b)	(b)	(b)
Ontario	1963	1,877	58.73	992,300
	1964	1,902	67.59	1,045,329
	1965	1,906	67.93	1,179,138
	1966	1,820	67.54	1,153,040
	1967	1,710	67.09	1,081,629

(a) Maximum allowance sharable by the federal government was increased from $65 to $75 a month as of December 1963.

(b) Effective April 1, 1965, payments were made to Quebec under the Established Programs (Interim Arrangements) Act.

TABLE 19 - BLINDNESS ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1967 (Concluded)

Province and year		Recipients in March	Average amount of monthly allowance	Federal government contribution during year(a)
		No.	$	$
Manitoba	1963	379	68.80	214,163
	1964	383	72.67	230,264
	1965	401	72.66	258,946
	1966	364	72.19	251,385
	1967	325	72.58	226,219
Saskatchewan	1963	422	63.18	240,693
	1964	406	71.51	246,010
	1965	391	72.02	256,063
	1966	366	71.74	248,004
	1967	272	71.60	204,547
Alberta	1963	463	63.53	271,516
	1964	465	72.65	278,014
	1965	475	72.36	311,992
	1966	448	72.38	307,676
	1967	412	71.89	284,078
British Columbia	1963	547	64.04	319,457
	1964	551	73.93	335,593
	1965	556	73.15	372,208
	1966	532	73.30	358,287
	1967	484	73.60	336,639
Yukon	1963	4	65.00	2,239
	1964	4	65.00	1,999
	1965	5	75.00	2,666
	1966	6	75.00	3,994
	1967	5	75.00	3,881
Northwest Territories	1963	46	59.13	23,452
	1964	46	64.14	27,214
	1965	49	74.39	32,746
	1966	44	75.00	32,310
	1967	38	75.00	28,069
Canada	1963	8,634	62.50	4,881,829
	1964	8,581	68.12	4,987,897
	1965	8,586	72.10	5,624,702
	1966	5,437(b)	71.05(b)	3,632,212(b)
	1967	5,022(b)	70.94(b)	3,377,418(b)

(a) Maximum allowance sharable by the federal government was increased from $65 to $75 a month as of December 1963.
(b) Excludes Quebec.

Subsection 5 - Allowances for Disabled Persons

The Disabled Persons Act of 1954, as amended, provides for federal reimbursement to the provinces for allowances paid to permanently and totally disabled persons age 18 or over who are in need and who meet the required definition of "permanent and total disability", the ten years' residence requirement and specified income limits. For an unmarried person, total income including the allowance may not exceed $1,260 a year. For a married couple the limit is $2,220 a year except that if the spouse is blind within the meaning of the Blind Persons Act, income of the couple may not exceed $2,580 a year.

The federal contribution may not exceed 50 per cent of $75 a month or of the allowance paid, whichever is less. The province administers the program and, within the limits of the federal Act, may fix the amount of allowance payable, the maximum income allowed and other conditions of eligibility. Effective April 1, 1965, Quebec withdrew from this federal-provincial program under the Established Programs (Interim Arrangements) Act, which entitles the province to a tax abatement and an equalization payment.

Under the terms of the Canada Assistance Plan a province may elect to aid needy disabled persons under a general assistance program with costs shared under the Canada Assistance Plan (see p. 69). In accordance with this provision several provinces no longer accept applications under the Disabled Persons Allowances Act. They may also transfer current recipients of disabled persons allowances to their general programs, provided that there is no decrease in benefits. The provinces are gradually taking steps to alter their programs in this way.

TABLE 20 - DISABLED PERSONS' ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1967

Province and year		Recipients in March	Average amount of monthly allowance	Federal government contribution during year(a)
		No.	$	$
Newfoundland	1963	1,436	64.61	532,852
	1964	1,586	64.53	587,092
	1965	1,746	74.63	750,279
	1966	1,817	74.49	804,197
	1967	1,873	74.55	833,340
Prince Edward Island	1963	795	64.40	311,831
	1964	801	64.47	310,817
	1965	797	74.31	360,150
	1966	788	74.25	349,881
	1967	814	74.35	368,992
Nova Scotia	1963	2,919	63.84	1,113,882
	1964	3,108	73.79	1,229,805
	1965	3,329	73.88	1,446,725
	1966	3,474	73.92	1,524,103
	1967	3,522	73.88	1,584,061
New Brunswick	1963	2,060	64.51	791,069
	1964	2,141	74.39	859,995
	1965	2,263	74.36	987,471
	1966	2,320	74.34	1,030,637
	1967	2,266	74.36	1,041,900
Quebec	1963	21,347	64.33	8,577,890
	1964	20,753	64.29	8,081,258
	1965	20,171	74.23	9,090,736
	1966	(b)	(b)	(b)
	1967	(b)	(b)	(b)
Ontario	1963	14,886	63.69	5,537,215
	1964	15,938	73.43	6,182,921
	1965	17,222	73.23	7,378,219
	1966	18,406	73.10	7,823,576
	1967	19,800	72.02	8,377,469

(a) Maximum allowance sharable by the federal government was increased from $65 to $75 a month as of December 1963.

(b) Effective April 1, 1965, payments were made to Quebec under the Established Programs (Interim Arrangements) Act.

TABLE 20 - DISABLED PERSONS' ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1963 TO 1967 (Concluded)

Province and year		Recipients in March	Average amount of monthly allowance	Federal government contribution during year(a)
		No.	$	$
Manitoba	1963	1,520	64.19	577,685
	1964	1,518	74.09	615,287
	1965	1,538	73.96	679,916
	1966	1,566	73.80	688,650
	1967	1,547	73.91	687,543
Saskatchewan	1963	1,602	64.46	630,838
	1964	1,657	74.27	669,547
	1965	1,780	74.18	784,700
	1966	1,871	74.08	824,777
	1967	390(b)	70.94	189,817
Alberta	1963	1,780	63.56	697,294
	1964	1,815	73.44	727,595
	1965	1,874	73.56	830,170
	1966	1,933	73.18	851,033
	1967	1,931	72.89	859,166
British Columbia	1963	2,248	64.18	853,602
	1964	2,319	74.04	929,723
	1965	2,336	73.94	1,037,484
	1966	2,385	73.86	1,061,500
	1967	2,422	73.75	1,071,978
Yukon	1963	7	65.00	2,358
	1964	3	68.33	2,262
	1965	2	75.00	1,148
	1966	2	75.00	900
	1967	2	75.00	900
Northwest Territories	1963	21	65.00	7,797
	1964	32	65.31	10,745
	1965	45	75.00	18,435
	1966	26	74.47	19,376
	1967	23	74.62	11,212
Canada	1963	50,621	64.10	19,634,313
	1964	51,671	69.48	20,206,543
	1965	53,103	73.86	23,365,493
	(c)1966	34,588	73.51	14,979,430
	(c)1967	34,590	73.57	15,026,378

(a) Maximum allowance sharable by the federal government was increased from $65 to $75 a month as of December 1963.
(b) Most recipients transferred to provincial general assistance program.
(c) Excludes Quebec.

Subsection 6 - Fitness and Amateur Sport

The Fitness and Amateur Sport Act of 1961, administered by the Minister of National Health and Welfare, provides up to five million dollars a year to be spent on the encouragement, promotion, and development of active leisure pursuits for everyone in Canada. Although the federal, provincial, and municipal governments provide the funds and resources, the programs are carried out almost entirely by nongovernmental agencies. Under the Act, Canadian participation in active recreation and amateur sport can be promoted internationally, nationally, provincially, and locally through financial assistance, technical guidance, the provision of teaching materials, assistance to training, research, and the construction of facilities. The National Advisory Council of Fitness and Amateur Sport advises the Minister of National Health and Welfare in fitness and amateur sport matters; its 30 members are chosen for their interest and experience, with at least one member from each province.

The federal program has five elements. Grants to National Organizations, totalling more than a million dollars a year, go to some 50 national fitness and sporting organizations to help to train coaches, to improve standards of instruction, to increase participation in sports, to aid the holding of national and regional competitions, and to assist Canadian Athletic teams at international competitions. Grants for Athletic Events of nation-wide interest assist the holding of such events as the 1967 Pan-American Games in Winnipeg and the 1967 Canadian Winter Games in the Quebec area. Grants for Training and Research are made for graduate study in fitness and amateur sport, for research fellowships, and for scholarships and bursaries for undergraduate study in Physical Education and Recreation.

Services of the Department of National Health and Welfare include the provision of technical advice, training material, and promotional aids. Visual aids for coaching, printed guides on particular sports and recreational activities, and technical information on the construction and use of facilities are provided. Typically Canadian sporting and recreational activities have been fostered by "How To" kits that include an illustrated manual, a film to rouse interest

in the subject, and films in which techniques are demonstrated; these kits and other films are available on loan from the Department's Fitness Film Library. Committees of the National Advisory Council meet frequently with the executives of sports organizations to discuss policy and a federal-provincial committee of government officials advises on and co-ordinates governmental aspects of the program. The Department also co-ordinates work done by other federal agencies in fitness and amateur sport. Grants to the Provinces of $1 million a year are made to those that enter into cost-sharing agreements for provincial programs of fitness and amateur sports. The federal government meets 60 per cent of the cost of projects and the full cost of the undergraduate scholarships and bursaries. Applications for all grants at the provincial or local level are made in the first instance to the responsible provincial department.

The Municipal Role. The bulk of recreational activity occurs in the individual community and municipal recreation departments co-ordinate community effort, provide continuity for voluntary organizations, and make long-range recreational plans. Thus, most ideas originate in the municipal recreation departments, where the needs of the communities are best known.

Subsection 7 - National Welfare Grants

The National Welfare Grants program was established in 1962 to help develop and strengthen welfare services in Canada through a general welfare and professional training grant and a welfare research grant. In the year ending March 31, 1968, $2,500,000 has been allocated to the program. The program is designed to strengthen and to develop welfare services in Canada. The variety of provisions within the program, along with its associated consultative and technical services, allow it to operate as a flexible instrument in the development of welfare services and to give a major emphasis to experimental activities in the welfare field.

Of particular importance in the development of services is the support given to preventive programs, which are pro-

vided on a general or community-wide basis. Such support also enables the National Welfare Grants program to fulfil a complementary role to other programs restricted in their financial support to services for specific categories of people. In its experimental role, support is given to research and demonstration projects that contribute to the growth of knowledge in the welfare field, that make possible the collection of comprehensive and reliable data essential to program development, or that lead to the practical application of knowledge and experience to welfare services for the purpose of improving those services by means of encouraging their wider use, by building new qualities into them, or by introducing innovations in their use.

Provincial governments, municipal welfare departments, nongovernmental welfare and correctional agencies, universities, and individuals may be the ultimate recipients of grants under one or more provisions of the program. Some are financed and administered entirely by the federal government; others require application through a provincial department of welfare that actually makes the award on a cost-sharing basis with the federal government.

General welfare, bursary, training, and staff development grants are shared provisions. General welfare grants provide funds for projects to improve welfare administration, to develop provincial consultative and coordinating services, and to strengthen and extend public and voluntary welfare services in child welfare, aging, general assistance, and other welfare fields. Bursaries are provided for full-time graduate training at Canadian schools of social work, and training grants are available for employees of government and voluntary welfare agencies. Staff development grants provide support for a wide variety of staff training programs for personnel employed, or to be employed, in public and nongovernmental welfare agencies.

The other provisions of the program are administered by the federal government. Welfare scholarships are awarded for graduate study in Canadian schools of social work and fellowships for advanced study at Canadian and foreign universities. Teaching and field instruction grants assist Canadian schools of social work with the salaries of additional staff required to implement the welfare grants program. Under the welfare research grant, funds are pro-

vided for a variety of research studies undertaken by public and voluntary welfare and correctional agencies, universities and research institutions.

Effective 1 April 1967, a mental retardation grant, established for 5 years only, will be administered in conjunction with the National Welfare Grants program. With the need to emphasize prevention in this field, support will be given to research and demonstration projects designed to expand knowledge and to apply that knowledge along with experience to new ways of providing services to prevent the continuing growth in the burden of disability due to retardation.

Expenditures under the program for the year ended March 31, 1967, appear in Table 21.

Subsection 8 - Vocational Rehabilitation

The federal-provincial vocational rehabilitation program, which began in 1952, was consolidated and extended under the Vocational Rehabilitation of Disabled Persons Act, 1961. Federal-provincial agreements under this Act provide for equal sharing of costs between the federal government and the provinces. These costs include co-ordination and provision of services to disabled or other vocationally disadvantaged individuals, training of rehabilitative personnel and research and publicity. Approved services, supplied by a provincial government or purchased from voluntary agencies by a provincial government, comprise medical, social and vocational assessment, counselling restorative services, the provision of prostheses, vocational training or educational upgrading, rehabilitation allowances and tools, books and equipment. Vocational training has been arranged under the provisions of the Technical and Vocational Training Assistance Act, which provides for equal sharing by Canada and the provinces of the cost of training disabled persons. Employment placement is provided through Canada Manpower Centres of the Department of Manpower and Immigration.

In each participating province a provincial co-ordinator or director of rehabilitation is responsible for the co-ordination and administration of services to disabled or vocationally disadvantaged persons. The federal aspects

TABLE 21 - FEDERAL EXPENDITURES UNDER THE NATIONAL WELFARE GRANTS PROGRAM, BY PROVISION AND PROVINCE, YEAR ENDED MARCH 31, 1967

Province	Payments through Provinces		Direct Payments				Totals
	Welfare Service Plan(a)	Demonstration Project(b)	Teaching and Field Instruction(c)	Scholarships and Fellowships(d)	National Voluntary Welfare Agency Projects(e)	Welfare Research(e)	
	$	$	$	$	$	$	$
Newfoundland	3,900	-	-	3,992	-	-	7,892
Prince Edward Island	11,393	25,000	-	-	-	-	36,393
Nova Scotia	6,575	24,442	40,197	6,032	5,073	10,563	92,882
New Brunswick	12,331	--	-	-	-	-	12,331
Quebec	-	-	-	35,558	-	-	35,558
Ontario	203,829	49,953	166,520	64,261	56,619	69,888	611,070
Manitoba	-	-	70,420	-	-	39,091	109,511
Saskatchewan	7,800	16,008	-	5,940	-	8,996	38,744
Alberta	18,080	-	21,296	5,044	-	3,500	47,920
British Columbia	28,065	66,336	81,467	23,224	-	39,465	238,557
Yukon	18,875	-	-	-	-	-	18,875
Northwest Territories	28,350	-	-	-	-	-	28,350
Canada	339,198	181,739	379,900	144,051	61,692	171,503	1,278,083

(a) Require a matching contribution of provincial and/or municipal funds
(b) Financed out of federal allocations to the provinces but do not require matching
(c) By location of school (d) By home address of recipients (e) By location of agency head office

of the program are administered by the Director, Vocational Rehabilitation, Department of Manpower and Immigration, Ottawa. In the fiscal year 1966-67, federal-provincial expenditures under the program (exclusive of vocational training) totalled $2,050,083. Reports were received on 2,679 disabled or vocationally disadvantaged persons rehabilitated during the year. Before rehabilitation the cost of supporting these people and their dependents was an estimated annual amount of $2,045,512. After rehabilitation the estimated annual earnings of those gainfully employed were $7,084,755.

Liaison with the provinces was carried out from Ottawa and the vocational rehabilitation staff supplied specialist consultative services. In keeping with the organizational structure and decentralization policy of the new Department of Manpower and Immigration, planning was carried out for the gradual assumption of these responsibilities by the five regional manpower offices of the department's Canada Manpower Division.

The Ottawa Headquarters' Vocational Rehabilitation Branch, through its Section on Older Workers, also has the function of encouraging a more favourable employment climate for older workers. This function is carried out by a long-range educational program, the encouragement of research, the maintenance of liaison with employer and labour organizations and voluntary agencies in Canada, the assembly and dissemination of informational material, and supportive services to the regional manpower offices and their Canada Manpower Centres.

During 1966-67, there was a broader acceptance of the idea that vocational rehabilitative services, which had worked successfully for the physically or mentally disabled, could be applied with equal benefit to socially disadvantaged persons. These other individuals include older workers, parolees, ex-convicts, people with personal, attitudinal, emotional or family problems and those with significantly low educational levels or lacking in knowledge of the world of work.

Among other agencies contributing to vocational rehabilitation are the Workmen's Compensation Boards in all provinces which provide for the rehabilitation of injured workmen.

As approved by provincial health departments, the Prosthetics Services established for veterans are being extended to the general public through 12 prosthetic centres administered by the Department of National Health and Welfare.

Subsection 9 - National Council of Welfare

Co-ordination in welfare matters between different levels of government and between government and voluntary authorities is facilitated by the National Council of Welfare, an advisory body to the Minister of National Health and Welfare. The Council consists of the Deputy Minister of National Welfare as the chairman, the provincial deputy ministers of welfare, and ten other persons appointed for three-year terms by the Governor in Council. The National Council of Welfare held its first meetings in Ottawa during April and November 1965.

Section 3 - Provincial Welfare Programs

Major welfare programs governed by provincial legislation include general assistance and social allowances, mothers' allowances, services for the aged, and child welfare services. Also, the Province of Quebec has established and is operating the Quebec Pension Plan, which is comparable to the Canada Pension Plan. Both Plans commenced in January 1966 and are closely co-ordinated (see p. 52). Quebec has also enacted in 1967 its own family allowances program (see p. 105). In most provinces, responsibility for a number of the programs is shared by the provinces and their municipalities. Provincial administration is carried out through the department of public welfare in each province; several departments have established regional offices to facilitate administration and to provide consultative services to the municipalities.

The provincial departments of public welfare are placing increasing emphasis on standards of administration and on rehabilitative services for social assistance recipients. Several provinces have recently introduced legislation under which the Province will share with the municipalities the costs of preventive and rehabilitative welfare services.

Public services are supplemented by those of voluntary agencies whose interests include the welfare of families and children and of groups with special needs, such as the aged, recent immigrants, youth groups, and released prisoners. Welfare councils and social planning councils contribute to the planning and co-ordinating of local welfare services. Local voluntary agencies and institutions may receive public grants, depending on the nature and standard of their services although their main support is usually from united funds or community chests, or from sponsoring organizations.

Subsection 1 - Mothers' Allowances

All provinces make provision for allowances to needy mothers with dependent children. A number of provinces combine such allowances into a broadened program of provincial allowances to persons in several categories of long-term need or have incorporated this legislation with general assistance within a single Act.

Subject to conditions of eligibility which vary from province to province, mothers' allowances or their equivalents are payable to applicants who are widowed, or whose husbands are mentally incapacitated or are physically disabled and unable to support their families. They are also payable to deserted wives who meet specified conditions; in several provinces to mothers whose husbands are in penal institutions or who are divorced or legally separated; in some, to unmarried mothers; and in Ontario, Quebec, and Nova Scotia, to Indian mothers. Foster mothers may be eligible under particular circumstances in most provinces.

The age limit for children is 16 years in most provinces, with provision made to extend payment for a specified period if the child is attending school or if he is physically or mentally handicapped. Rates of allowances and the amount of outside income and resources allowed vary by province.

Costs of allowances and services are sharable with the federal government under the Canada Assistance Plan (see p. 69).

The number of families and children assisted in each province as at March 31, 1966, together with the amounts of benefits paid during the year are given in Table 22 and rates of benefits as at April 1967 in Table 23.

Subsection 2 - General Assistance

All provinces make legislative provision for general assistance on a means or needs test basis to needy persons and their dependents who cannot qualify for other forms of aid, and some provinces include those whose benefits under other programs are not adequate. Where necessary the aid may be for maintenance in homes for special care. In addition to financial aid for the basic needs of food, clothing, shelter, and utilities, a number of provinces provide incapacitation or rehabilitation allowances, counselling and homemaking services, and post-sanatorium care. This assistance is administered by the province or by the municipalities with substantial financial support from the province, which, in turn, is reimbursed by the federal government under the Canada Assistance Plan for 50 per cent of the provincial and municipal assistance given (see p. 69).

The provincial departments of public welfare have regulatory and supervisory powers over municipal administration of general assistance and may require certain standards as a condition of provincial aid. Length of residence is not a condition of aid in any province, but in four provinces the residence of the applicant as defined by statute determines which municipality may be financially responsible for his aid. Municipal residence is not a factor in British Columbia and Saskatchewan which have equalized municipal payments, in Quebec where municipalities may administer the general assistance program but are not required to contribute to the cost of allowances, or in Newfoundland, Prince Edward Island and New Brunswick where aid is administered provincially. The provincial authority takes responsibility for aid in unorganized areas within the province. Under the

TABLE 22 - MOTHERS' ALLOWANCE STATISTICS, BY PROVINCE, AS AT MARCH 31, 1962 TO 1966

Province and year		Families assisted	Children assisted	Payments during the year ended March 31
		No.	No.	$
Newfoundland	1962	4,498	12,315	4,308,762
	1963	4,836	13,216	4,687,760
	1964	5,172	14,418	5,100,590
	1965	5,382	14,538	5,343,344
	1966	5,733	15,191	5,660,494
Prince Edward Island..	1962	269	649	131,300
	1963	293	747	140,885
	1964	314	778	212,265
	1965	314	760	247,455
	1966	370	917	254,651
Nova Scotia	1962	2,754	7,452	2,258,875
	1963	2,760	7,477	2,311,725
	1964	3,331	8,100	2,533,311
	1965	3,436	8,449	2,684,337
	1966	3,361	8,147	2,659,400
New Brunswick	1962	2,119	6,178	1,356,078
	1963	2,165	6,287	1,347,479
	1964	2,254	6,364	2,030,948
	1965	2,284	6,282	2,089,325
	1966	2,222	6,025	2,046,539
Quebec	1962	19,842	52,462	19,479,716
	1963	19,531	54,638	20,743,405
	1964	19,222	54,366	22,538,118
	1965	15,785	48,076	21,067,715
	1966	15,816	47,898	20,882,058
Ontario	1962	10,359	25,537	13,650,401
	1963	10,175	25,522	13,913,657
	1964(a)	10,700	27,600	15,553,856
	1965(a)	12,073	31,273	17,043,696
	1966(a)	13,621	45,359	22,529,712

(a) Includes dependent fathers assisted under the General Welfare Assistance Act.

TABLE 22 - MOTHERS' ALLOWANCE STATISTICS, BY PROVINCE, AS AT MARCH 31, 1962 TO 1966 (Concluded)

Province and year		Families assisted	Children assisted	Payments during the year ended March 31
		No.	No.	$
Manitoba	1962(a)	1,638	3,635	2,360,594
	1963	1,811	3,823	2,576,796
	1964	1,845	4,150	2,776,762
	1965	1,975	4,499	3,047,284
	1966	2,256	4,916	3,396,562
Saskatchewan	1962	2,382	5,837	2,679,587
	1963	2,459	6,158	3,512,769
	1964	2,466	6,255	3,669,427
	1965	2,461	6,276	3,811,472
	1966	2,380	6,230	3,844,144
Alberta	1962	1,611	3,319	1,879,195
	1963(b)	1,210	2,361	1,407,020
	1964(b)	931	1,760	1,009,867
	1965(b)	679	1,246	741,105
	1966(b)	457	813	503,075
British Columbia(c) ..		...	...	...
		...	...	...
		...	...	...
Canada(d)	1962	45,477	117,384	48,104,508
	1963	45,240	120,229	50,641,496
	1964	46,235	123,791	55,425,144
	1965	44,389	121,399	56,075,733
	1966	46,216	135,496	61,776,635

(a) Approximate.
(b) Additional families were assisted under Part III of the Public Welfare Act: in 1963 an additional 2,563 families with 7,542 children; in 1964, 3,275 families with 9,774 children; in 1965, 4,106 families with 12,540 children; and in 1966, 5,163 families with 15,222 children. Cost of allowances for this group is not segregated from other allowances under Part III.
(c) Caseload merged with the social assistance; no separate figures are available.
(d) Exclusive of British Columbia.

TABLE 23 - MAXIMUM MONTHLY RATES OF ASSISTANCE TO NEEDY MOTHERS WITH DEPENDENT CHILDREN UNDER PROVINCIAL MOTHERS' ALLOWANCES OR EQUIVALENT PROGRAMS, APRIL 1967

Province	Mother and one child (1)	Each additional child (2)	Supplementary (3)
Nfld.	$140-165 depending on place of residence. Food: Adult $35; child $20 Clothing and personal care: Adult $15; child $5 Fuel: $15 Household maintenance and utilities: $25 Rent: $25 (rural); $50 (urban) $35 a month for a child living with a guardian.	Food: $20 Clothing: $5	Up to $50 a month may be granted under special circumstances.
P.E.I.1/	$118-143 (exclusive of fuel and utilities) depending on age of child and place of residence. Food: Adult $30; child under 12 years, $15; child over 12 years, $20 Clothing: Adult $15; child $10 Household and personal needs: Adult $6; child $2 Rent: $40 (rural); $60 (urban) Fuel and utilities: actual cost as cost is based on previous year's expenditure.	$25 for child under 12 years; $30 for child over 12 years. Rates for food and clothing as in Column (1).	Fuel allowance may be increased from October 1 - May 31. An allowance of up to $150 may be granted in cases of special need. An increase in the food allowance may be made for special diets on medical recommendation.
N.S.	$126-140 representing 70 per cent of maximum budget deficit of $180-200 depending on age of child and based on the following costs: Food: Adult $24; child, 12-18 years, $28; 7-11 years, $20; birth - 6 years, $14 (For family of two rates are increased by 10 per cent.) Clothing: Adult $9; child 12-18 years, $10; 7-11 years, $7; birth - 6 years, $6 Miscellaneous essentials: Adult $4; child 12-18 years, $5; child 7-11 years, $4; child birth - 6 years, $3 Rent: up to $100. The total allowance for rent (or mortgage payments and taxes) fuel, electricity and water may not exceed $115. $25 for a foster child living with a foster mother.	Rates as in Column (1) included in calculation of budget deficit. (Food allowance adjusted by an increase of 10 per cent for a family of three and by a deduction of 5 per cent for a family of six or more persons.) $20 for each additional foster child. (Family maximum - $150)	Home owners may be granted $12 a month for house maintenance.

TABLE 23 - MAXIMUM MONTHLY RATES OF ASSISTANCE TO NEEDY MOTHERS WITH DEPENDENT CHILDREN UNDER PROVINCIAL MOTHERS' ALLOWANCES OR EQUIVALENT PROGRAMS, APRIL 1967

Province	Mother and one child (1)	Each additional child (2)	Supplementary (3)
N.B.1/	$102-127 (exclusive of fuel and utilities) depending on age of child and place of residence. Food: Adult $26 ($6 a week) child under 12 years, $13 ($3 a week) child over 12 years, $17.50 ($4 a week) Clothing: Adult $10; child $5 Household and personal needs: Adult $6; child $2 Rent: $40 (rural); $60 (urban) Fuel and utilities: on basis of actual cost as cost is based on previous year's expenditure.	$20 for child under 12 years; $24.50 for child over 12 years. Rates for food, clothing and personal care as in Column (1).	The fuel allowance may be increased from October 1 - May 31. An allowance of up to $150 may be granted in cases of special need. An increase in the food allowance may be made for special diets on medical recommendation.
Que.	$95	$20	A supplementary allowance according to need may be granted.
Ont.	$173-209 depending on age of child, and whether premises are heated or unheated: Pre-added budget (food, clothing, utilities, household supplies and personal requirements) depending on age of child: $88-102 Shelter: $75 (unheated); $85 (heated) Fuel: up to $32 (Sept.-March; Aug.-April in territorial districts) $45 for one foster child living with a foster mother.	Depending on age of child; $21-33 for 2nd child; $26-39 for 3rd child; $24-37 for each of 4th and 5th child; $23-36 for 6th child. $40 for second foster child. $30 for third and each additional foster child. (Family maximum - $300 for a family of not more than four persons; increased by $10 a month for each person in excess of four.)	An increase in the amount of the pre-added budget may be made for special diets on medical recommendation. Shelter allowance is increased by $5 a month for each beneficiary in excess of two. Fuel allowance may be increased under special circumstances.
Man.	$129.50-145.50 (exclusive of fuel allowance) depending on age of child. Food: Adult $26; child 15-19 years, $30; child 12-14 years, $27; child 7-11 years, $22; child 4-6 years, $18; child birth - 3 years, $16. (For a family of two, the above amounts are increased by $3 for each person) Clothing: Adult $5; child 12-17 years, $6; child 7-11 years, $5; child birth - 6 years, $4 Rent: up to $55 or up to $65 if fuel and/or utilities are included Household and personal needs: $10 Utilities: up to $7.50 Fuel: (Oct.-May inclusive) up to $20	$20-36 depending on age of child. Rates for food and clothing as in Column (1). The food allowance is increased by $1 per person for a family of three, and for a family of 5 or more a deduction of $2 is made for each person in excess of five.	An allowance of up to $150 a year may be granted for special needs. An additional amount of $7.50 a month may be allowed for utilities and an additional grant of up to $50 may be made at the end of the winter fuel season.

TABLE 23 - MAXIMUM MONTHLY RATES OF ASSISTANCE TO NEEDY MOTHERS WITH DEPENDENT CHILDREN UNDER PROVINCIAL MOTHERS' ALLOWANCES OR EQUIVALENT PROGRAMS, APRIL 1967(Concluded)

Province	Mother and one child (1)	Each additional child (2)	Supplementary (3)
Sask.1/	$101.30-119.10 (exclusive of fuel and utilities allowance) depending on age of child. Food: Adult $26.50; child 15-19 years, $28; child 10-14 years, $26; child 5-9 years, $21; child birth-4 years, $14.50 Clothing: Adult $10; child 15-19 years, $8; child 10-14 years, $7.50; child 5-9 years, $6.80; birth-4 years, $5 Personal Care: Adult $3.25; child 15-17 years, $1.75; child 10-14 years, .85; child 5-9 years, .60; child birth-4 years, .45 Laundry, Cleaning and Household Supplies: $1.60 Rent: $40 Fuel: May be granted on basis of actual cost of fuel in the locality or according to a schedule of rates which varies by locality, type of fuel, and number of rooms. Utilities: May be granted on basis of actual cost.	$19.95-37.75 depending on age of child. Rates for food and clothing as in Column (1). Rent allowance is increased by $5 for each additional person up to 6 persons.	Special food allowance may be granted on medical recommendation.
Alta.	Food and Clothing: $52.84-74.65 depending on age of child. Food: Mother $24; child, $13.60-32.50 depending on age and sex. For family of two food allowance may be increased by 10 per cent. Clothing: Mother, $9; child, $4.30-10.70 depending on age and sex. Rent, fuel, utilities: according to community standards.	$19.80-41.60 depending on age and sex of child.	An increase in the food allowance may be granted for special diets on medical recommendation.
B.C.1/	$135 Food: $70 Clothing, fuel, operating and sundries: $20 Shelter: $45	$25	An additional allowance may be granted in special circumstances. An increase in the food allowance may be granted for special diets on medical recommendation.

1/ General social assistance rates. The mothers' allowances program has been amalgamated with the social assistance program. In Prince Edward Island and New Brunswick aid to all needy persons is administered by the Province; in Saskatchewan and British Columbia the general assistance program is administered by the local welfare authority and in unorganized territory, by the Province.

federal Unemployment Assistance Act and subsequently under the Canada Assistance Plan, all provinces have agreed that residence shall not be a condition of assistance for applicants who move from one province to another. For persons without provincial residence (usually a period of one year), aid may be given by the province or the municipality and a charge-back may be made to the province or municipality of residence.

The formula for provincial-municipal sharing of costs is determined by the province. In 1966 a number of provinces made major changes in the administration of assistance; in two provinces, Prince Edward Island and New Brunswick, the municipalities were relieved of responsibility for the administration and financing of aid. In Newfoundland, general assistance is the responsibility of the province and is administered by the Department of Public Welfare. In Prince Edward Island, the Department of Welfare assumed full responsibility for the administration of all assistance in the province as of October 26, 1966. In Nova Scotia the Department of Public Welfare revised the cost sharing formula effective August 1, 1966 so that the amount of reimbursement varies by municipality; for assistance and services to needy persons it varies from 75 per cent to 89.65 per cent and for administrative expenses it varies from 50 per cent to 89.65 per cent. In New Brunswick the Department of Youth and Welfare assumed full responsibility for the administration of assistance to needy persons within the province from January 1, 1967.

In Quebec, the Department of Family and Social Welfare reimburses authorized agencies and municipal departments for the full cost of aid to persons in their own homes. It takes full responsibility for aid to persons who are unfit for work for at least 12 months, for supplementary allowances and allowances to needy widows and spinsters 60-65 years of age. The cost of aid to unemployable persons in homes for special care, including nursing homes, is borne two-thirds by the province and one-third by the institution.

In Ontario, the Department of Social and Family Services reimburses municipalities up to a prescribed maximum for 80 per cent of their expenditures for general welfare assistance, and for 90 per cent of expenditures for aid to persons in excess of a given proportion of the population in the municipality. Aid for rehabilitation services and

aid on behalf of foster children, for which the municipalities are reimbursed 50 per cent, are excluded in these calculations. The province administers allowances to needy widows and unmarried women 60 years of age or over. Since November 1965, the province has reimbursed counties and municipalities for 50 per cent of salaries paid to staff employed full time in the administration of welfare services, and 50 per cent of travelling expenses related to the administration of welfare services.

In Manitoba, the province administers aid to mentally or physically incapacitated persons whose disability is likely to last more than 90 days, and to persons unable to work because of their age. Financial aid or services to other needy persons, termed indigent relief, is the responsibility of the municipalities, which are reimbursed through the provincial Department of Welfare to the extent of 40 per cent of the costs, or at a higher rate if costs exceed a specified amount. In Saskatchewan, through the Department of Welfare, the province reimburses the municipalities for approximately 95 per cent of the cost of assistance and services granted to needy persons. In Alberta, the province reimburses the municipalities for 80 per cent of the value of the assistance given and since April 1, 1966, for 80 per cent of the costs of administration and of certain preventive social services. The provincial Department of Public Welfare has full responsibility for allowances payable to persons who are mentally or physically handicapped for a period likely to last for more than 90 days, and to persons who because of their age are not able to be self-supporting. The Department maintains two hostels and one welfare centre to care for unemployable single homeless men without municipal domicile.

British Columbia, through its Department of Social Welfare, reimburses the municipalities on a pooled basis for 90 per cent of the total cost of social assistance to needy persons. Also, the province shares equally with the municipalities expenditures on salaries of social workers; a municipality with fewer than 15,000 persons may arrange to have the Department undertake social work within the municipality and reimburse it at the rate of 60 cents per capita per year.

Subsection 3 - Living Accommodation for Elderly Persons

In all provinces, homes for the aged and infirm are provided under provincial, municipal, or voluntary auspices. Voluntary homes generally are provincially inspected in accordance with prescribed standards and in some provinces must be licensed. The provinces contribute to the maintenance of needy persons in homes for the aged, either through general assistance or through statutes that relate particularly to these homes. Also, 50 per cent of the payments on behalf of assistance cases in homes for the aged and infirm (homes for special care) are met by the federal government (see p. 71).

All provinces in varying degrees make capital grants toward the construction of homes, and in some provinces capital grants are also available to municipalities, charitable organizations, or non-profit corporations for the construction of low-rental housing.

Newfoundland maintains a home for the aged and infirm at St. John's and pays part or all of the cost of maintaining needy old people in homes for the aged and boarding homes. Provision is made for grants to organizations constructing homes for the aged. The Senior Citizens (Housing) Act, 1960 provides for the construction of hostels or housing for the elderly by non-profit corporations. The province guarantees the cost of operating such projects. Three institutions operated by the Department of Welfare in Prince Edward Island and one operated by a charitable organization provide care for the aged and infirm. In Nova Scotia, the aged are cared for in municipal or county homes, in homes operated by religious or private organizations, and in private boarding homes. The province reimburses the municipalities for two-thirds of their expenditures for the maintenance of needy persons in municipal homes, subject to compliance with specified standards of care and accommodation. Homes for the aged receiving aid from the provincial government are subject to provincial inspection. In New Brunswick provincial grants may be made under the Senior Citizens Housing Act to assist non-profit housing corporations in constructing and equipping low-rental housing units for senior citizens. Homes for the aged are operated under public, charitable, and private auspices. Voluntary and

proprietary homes are subject to provincial licensing and inspection and must meet standards contained in regulations under the Health Act. Under the Social Welfare Act, 1966, the province contributes to the maintenance of needy persons in licensed nursing homes and homes for the aged.

Institutional care for indigent old people in Quebec is provided through charitable institutions under the Public Charities Act. The Aged Couples Homes Act authorizes the province to erect and maintain homes for aged couples, or to make agreements (including the provision of grants) for their erection, upkeep and administration with persons, societies and corporations, public or private. Standards established for homes for the aged are in accord with the regulations under the Public Health Act.

Under the Ontario Homes for the Aged and Rest Homes Act, municipalities must provide institutional or boarding-home care for the aged; they may also establish rest homes for the care of handicapped persons who cannot be properly cared for at home, in existing homes for the aged, hospitals or other institutions. The province contributes 50 per cent of the costs of construction of approved homes and 70 per cent of their operating and maintenance costs. It also pays up to 70 per cent of the costs of maintenance in approved boarding homes. Homes for the aged under voluntary auspices are approved, inspected, and assisted under the Charitable Institutions Act. This Act provides for construction grants up to $5,000 per bed and for maintenance grants of 80 per cent of the amount spent by the organization up to $6.00 per day for each resident where the institution maintains a bed-care unit of at least 20 beds and $4.00 where it does not. The Elderly Persons' Housing Aid Act provides for grants to non-profit housing corporations building low-rental housing for elderly persons.

Institutions and boarding homes for the aged and infirm in Manitoba are supervised and licensed by the Department of Health under public health legislation. The province makes construction grants equalling one-third of the costs of constructing or of acquiring and renovating housing accommodation and homes for the aged to municipalities and charitable organizations under The Elderly and Infirm Persons' Housing Act. Grants may not exceed $1,700 for one-

person housing units, $2,150 for two-person housing units, $2,000 per bed for new homes for the aged, and $1,000 per bed for homes that have been renovated. Under the Social Allowances Act the province bears the entire cost of allowances to those who, because of age, physical or mental ill health, or physical or mental incapacity, require care for more than 90 days by another person or in an institution or home for the aged and infirm.

In Saskatchewan, aged and infirm persons are cared for in four provincial geriatric centres (a fifth was transferred from the jurisdiction of the Department of Welfare to that of the Department of Public Health in early 1967) and in municipal, voluntary, and proprietary homes for the aged. The latter are inspected and licensed under The Housing and Special-care Homes Act. This Act also empowers the province and municipalities to subscribe to the capital stock of non-profit housing corporations building low-rental accommodation for older persons; the province may also make loans to municipalities to assist them in subscribing. Also, the province may guarantee the costs of operation of hostel-type accommodation with common dining and sitting rooms for aged persons. Capital grants amounting to 20 per cent of construction costs and annual maintenance grants of $40 for each self-contained housing unit and of $60 for each bed in a special-care home (that is, a nursing home, supervisory care home, or sheltered care home) may be made to municipalities, churches, or charitable organizations sponsoring approved homes or housing projects. Costs of maintaining needy persons in homes for the aged are shared by the province and the municipalities under the Saskatchewan Assistance Act.

Under what are termed "master agreements", Alberta bears the cost of constructing and equipping homes for the aged and housing units on municipal land. Projects are operated by provincially incorporated foundations which include municipal councillors in their membership; net costs of operation are borne by the municipalities. Aside from contract nursing homes, which come under specific legislation, and certain nursing homes under the supervision of the Department of Health, the Welfare Homes and Institutions Branch of the Department of Public Welfare is responsible for the licensing of and the maintaining of standards in homes for the aged and infirm.

A home for elderly homeless men is operated by the Department of Social Welfare in British Columbia. Boarding homes or institutional facilities for the care of the aged and infirm may be provided under municipal, non-profit or proprietary auspices. The province licenses and supervises homes for the aged and boarding homes and, where necessary, shares with the municipalities on a 90-10 basis the cost of maintaining needy residents. Under the Elderly Citizens' Housing Aid Act, the province makes grants amounting to one-third of construction costs to municipalities, regional districts and non-profit corporations, including religious and service organizations, engaged in building homes or low-rental housing units for elderly citizens.

Subsection 4 - Recreational Centres for Elderly Persons

Ontario gave impetus to the provision of recreation centres for older people through its Elderly Persons' Social and Recreational Centres Act, 1961-62. In 1966 The Elderly Persons Centres Act was passed. When proclaimed, it will replace the earlier legislation. The new Act continues the arrangement for a provincial grant of up to 30 per cent of the cost of constructing or buying a building for use as a recreational centre if the municipality contributes 20 per cent. In addition, provision is made for maintenance grants and special grants for services, facilities and research.

Subsection 5 - Child Welfare Services

Child welfare services, which include child protection and care, services for unmarried parents, and adoption services, are provided in all provinces under provincial legislation. The program may be administered by the provincial authority or the responsibility may be delegated to local children's aid societies (voluntary agencies with boards of directors, operating under charter and under the general supervision of provincial departments). In Newfoundland, Prince Edward Island, New Brunswick, Saskatchewan, and in Alberta, child welfare services are administered by the province; in Quebec they are administered by recognized

voluntary agencies and institutions, religious and secular; in Ontario, a network of local children's aid societies is responsible for the services; in Nova Scotia, Manitoba and British Columbia, services are administered by local children's aid societies in the heavily populated areas and by the province elsewhere.

Children's aid societies and the recognized agencies in Quebec receive substantial provincial grants and sometimes municipal grants and in many areas they also receive support from private subscriptions or from community chests or united funds. Maintenance costs for children in care of a voluntary or public agency, formerly borne by the province or partly by the municipality of residence and partly by the province, are sharable with the Federal Government under the Canada Assistance Plan (see p. 69).

The child welfare agencies, provincial or private, have the authority to investigate cases of alleged neglect and, if necessary, to apprehend a child and to bring the case before a judge upon whom rests the responsibility of deciding whether in fact the child is neglected. When neglect is proved, the court may direct that the child be returned to his parent or parents, under supervision, or be made a word of the province or a children's aid society. Services are provided as appropriate and include services to children in their own homes, care in foster boarding homes or adoption homes, or, for children who need it, in selected institutions. Children placed for adoption may be wards or they may be placed on the written consent of the parent. Adoptions, including those arranged privately, number about 15,500 annually.

Child welfare agencies make use of the small selective institution for placement of children who are forced to be away from their own homes for a short period or who may need preparation for placement in foster homes, and emphasis is increasingly being placed on group-living homes. The development of small, highly specialized institutions, which function as treatment centres for emotionally disturbed children, is of particular significance. Institutions for children are governed by provincial child welfare legislation and by provincial or municipal public health regulations; they are generally subject to inspection and in some provinces to licensing. Sources of income may include private sub-

scriptions, provincial grants, and maintenance payments on behalf of children in care, payable by the parents, the placing agency, or the responsible municipal or provincial department.

Services to unmarried parents include casework services to the mother and possibly to the father, legal assistance in obtaining support for the child from the father, and foster-home care or adoption services for the child. Support for unmarried mothers may be obtained under general assistance programs. In many centres, homes for unmarried mothers are operated under private or religious auspices.

Day nurseries for the children of working mothers are established only in the larger centres. These are chiefly under voluntary auspices, except in Ontario, where there are also municipally sponsored day nurseries operated with the aid of provincial grants.

Subsection 6 - The Province of Quebec's Family Allowances Program

The Province of Quebec introduced its own family allowances program under legislation enacted in 1967. Under this plan, the following allowances are paid at the end of each six-month period to persons satisfying the relationship and residence requirements in respect of children under 16 years of age: $15 for one child, $32.50 for two children, $52.50 for three children, $77.50 for four, $107.50 for five, $142.50 for six, and an extra $35 for each child after the sixth. These allowances are increased by $5 for each child between the ages of 12 and 16 years. To qualify for the allowances, children must be attending school regularly from the time when they are first required to do so, unless prevented by physical or mental infirmity.

Section 4 - International Welfare

Canada is actively involved in the social welfare and social development work of the United Nations and its Specialized Agencies and of various international voluntary organizations. At the United Nations Canada is represented on the Economic and Social Council and the Commission for Social Development, is a member of the governing bodies of the United Nations Children's Fund (UNICEF) and the International Labour Organization and actively participates in the work of a number of related organizations such as the Society for International Development and the International Social Security Association. The Department of National Health and Welfare provides representatives to such organizations, participates in international studies and contributes to the development of Canadian policy in this sector.

Under the External Aid Program, Canada supports a number of social welfare projects in developing regions as well as providing social work and social welfare training for foreign students recommended by their governments. The necessary technical services to the bilateral and multilateral aid programs in this sector are supplied by the Department of National Health and Welfare which also works closely with a number of Canadian voluntary organizations engaged in social development, many of which have technical personnel working in the field in addition to the direct assistance which they provide. The Overseas Institute of Canada acts as a clearing house and information centre for the voluntary sector.

PART III - HEALTH AND SOCIAL WELFARE EXPENDITURES

Section 1 - Government Expenditures on Health and Social Welfare

In the seven years ended March 31, from 1961 to 1967, expenditures by all levels of government on health and social welfare rose from $3,356,800,000 to a record high estimated at $5,369,500,000, an increase of 60 per cent. If these figures are adjusted to take account of the growth in population, the increase in per capita expenditures - from $186 to $266 - is about 43 per cent. Government expenditures may also be measured in relation to major economic indicators; on this basis, annual government expenditures on health and social welfare over the 1961-67 period have remained relatively stable, fluctuating between 11.8 and 12.8 per cent of net national income and between 8.8 and 9.6 per cent of gross national product; for the year ended March 31, 1967, the values were 12.2 and 9.1 per cent, respectively.

The federal share of health and social welfare expenditures fell from 70.4 per cent in 1960-61 to 60.7 per cent in 1966-67, the provincial share rose from 26.4 per cent to 36.9 per cent and municipal outlays declined from 3.2 per cent to 2.4 per cent. The relative federal declines in each of the three years since 1964-65 were caused to a substantial degree by increasing hospital expenditures by the provincial governments augmented, in the last two years, by the effect of the "opting out" arrangements made available to the provinces. Under the Established Programs (Interim Arrangements) Act, a province may "opt out" of federal-provincial programs, operate and finance these as provincial schemes and receive a tax abatement and an equalization payment from the federal government in lieu of a direct federal contribution to the program. This, of course, has the effect of showing an increase in provincial government expenditure while the federal fiscal payment is treated as a transfer payment. Thus, provincial expenditures include gross outlays by the Province of Quebec in respect of programs from which that province opted out, whereas the federal data do not include the large sums paid or transferred to that province under the Established Programs (Interim Arrangements) Act and other agreements. Compared with the previous year, 1965-66, health and social welfare expenditures by all levels of government increased by $673,700,000 or 14 per cent. Although outlays by all governments increased, provincial expenditures showed the greatest gain.

The proportion of government expenditures on health and social welfare taken up by health programs continues to grow; in 1960-61 such programs accounted for $934,000,000 or 28 per cent and in 1966-67 for $2,041,000,000 or 38 per cent.

An outline of the principal components for 1966-67 shows the magnitude of the major programs and services - family allowances payments amounted to $556,000,000, old age security payments to $1,033,000,000 plus another $40,000,000 for three months of the Guaranteed Income Supplement program, which began on Jan. 1, 1967, unemployment insurance benefits to $307,000,000, and veterans' pensions and allowances to $196,000,000 and $104,000,000, respectively. These income-maintenance programs were entirely the responsibility of the federal government. In addition, payments under the youth allowances program, which commenced in September 1964, amounted to $47,000,000 in 1966-67, excluding the Province of Quebec. That province had instituted a program of schooling allowances three years prior to the introduction of the federal program which necessitated a special arrangement with Quebec whereby that province continued its program, but with appropriate fiscal arrangements with the federal government.

Federal-provincial income-maintenance programs required expenditures of $42,000,000 for old age assistance, $4,600,000 for blindness allowances, $29,500,000 for disabled persons allowances and $260,000,000 for unemployment assistance, the latter including some municipal expenditures. Effective Apr. 1, 1965, Quebec withdrew from these federal-provincial programs under the Established Programs (Interim Arrangements) Act which entitled that province to a tax abatement as an equalization payment. Expenditures under the Canada Assistance Plan were estimated at $60,000,000 in 1966-67. This program was designed to replace the Unemployment Assistance Act, although certain costs not covered by the Plan may continue to be paid under that Act. The Canada Assistance Plan may also replace the old age assistance, blind persons allowances and disabled persons allowances programs at the option of each province (see p. 69). Workmen's Compensation Boards spent $160,000,000 on cash benefits for pensions and compensation. Welfare services for Indians and for veterans and the national employment service accounted for more than $65,000,000 at the federal level.

In the field of health, federal grants to the provinces under the Hospital Insurance and Diagnostic Services Act totalled almost $400,000,000 and grants for hospital construction and general health grants to the provinces and municipalities amounted to $53,000,000. The federal government spent $36,000,000 on its Indian and northern health services and $55,000,000 on hospital and treatment services for veterans. Provincial expenditures on hospital care are estimated to have totalled over $1,100,000,000, and $200,000,000 was spent on other health services. Workmen's Compensation Boards paid $70,000,000 for medical aid and hospitalization, and municipal governments spent $70,000,000 on health.

Section 2 - Expenditures on Personal Health Care

These comprise expenditures of hospitals, amounts received by physicians and dentists for professional services, and by pharmacists for prescription services (i.e., for prescription drugs that are sold in retail drugstores), and an estimate of the amounts that private nurses, chiropractors, osteopaths and optometrists receive for their professional services; they therefore exclude expenditures on public health, capital costs (buildings and interest) and administration costs of public-health programs and of insurance plans.

Table 26 shows the components for each year from 1955 to 1965. Canadians spent a total of $2,451 million on personal health care in 1965, almost three times as much as ten years before.

Expressed as a proportion of the gross national product, personal health care expenditures rose from 3.2 per cent in 1955 to 4.7 per cent in 1965. Expenditure per person over the same period changed from $55.40 in 1955 to $124.79 in 1965. Expressed in constant dollars, according to the consumers price index, the expenditure per person increased by 63 per cent over the same period, or by an average of 5 per cent per year.

TABLE 24 - TOTAL, PER CAPITA AND PERCENTAGE DISTRIBUTION OF GOVERNMENT EXPENDITURES ON HEALTH AND SOCIAL WELFARE, BY LEVEL OF GOVERNMENT, YEARS ENDED MAR. 31, 1961-67

Year Ended Mar. 31-	Federal	Provincial	Municipal	Total
	Total Expenditures			
	$'000,000	$'000,000	$'000,000	$'000,000
1961	2,362.1	885.7	109.0	3,356.8
1962	2,577.1	998.1	107.9	3,683.1
1963	2,683.5	1,086.8	117.3	3,887.6
1964	2,801.0	1,154.3	101.2	4,056.5
1965(1)	2,969.9	1,362.5	110.0	4,442.4
1966(1)	2,885.1	1,690.7	120.0	4,695.8
1967(1)	3,259.5	1,980.0	130.0	5,369.5
	Per Capita Expenditures			
	$	$	$	$
1961	131.16	49.20	6.05	186.41
1962	140.38	54.37	5.88	200.63
1963	143.66	58.18	6.26	208.10
1964	147.33	60.75	5.31	213.39
1965(1)	153.40	70.35	5.68	229.43
1966(1)	146.41	85.82	6.09	238.32
1967(1)	161.67	98.23	6.45	266.35
	Percentage Distribution			
1961	70.4	26.4	3.2	100.0
1962	70.0	27.1	2.9	100.0
1963	69.0	28.0	3.0	100.0
1964	69.0	28.5	2.5	100.0
1965(1)	66.9	30.6	2.5	100.0
1966(1)	61.4	36.0	2.6	100.0
1967(1)	60.7	36.9	2.4	100.0

(1) Estimated.

TABLE 25 - EXPENDITURES OF ALL LEVELS OF GOVERNMENT ON HEALTH AND SOCIAL WELFARE IN RELATION TO NET NATIONAL INCOME AND GROSS NATIONAL PRODUCT, FISCAL YEARS 1960-61 TO 1966-67

Fiscal year	Government expenditures on health and social welfare		
	Amount	Per cent of net national income	Per cent of gross national product
	($ millions)		
1960-61	3,356.8	12.2	9.2
1961-62	3,683.1	12.8	9.6
1962-63	3,887.6	12.5	9.5
1963-64	4,056.5	12.1	9.1
1964-65	4,442.4 (a)	12.3	9.2
1965-66	4,695.8 (a)	11.8	8.8
1966-67	5,369.5 (a)	12.2	9.1

(a) Includes estimated data.

TABLE 26 - EXPENDITURES ON PERSONAL HEALTH CARE, CANADA, 1955-1965

Year	Hospital Services					Physicians' Services	Prescribed Drugs(c)	Dentists' Services	Other Personal Health Services(d)	Total
	General and Allied Special Hospitals	Psychiatric Institutions	Tuberculosis Sanatoria(a)	Government of Canada(b)	All Hospitals					
	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000
1955	342.4	68.9	29.9	38.8	480.0	206.5	59.5	68.6	55.0	869.6
1956	380.8	77.6	30.6	40.8	529.8	240.1	71.8	81.5	65.0	988.2
1957	422.9	87.5	31.0	45.3	586.7	271.8r	84.5	87.3	70.0	1,100.3r
1958	462.3	99.0	30.4	48.4	640.1	301.3r	90.3	98.1	85.0	1,214.8r
1959	542.6	111.6	29.6	50.3	734.1	325.7r	106.5	98.7r	95.0	1,360.0r
1960	625.2	120.2	30.1	53.9	829.4	355.0r	109.6r	109.6r	105.0	1,508.6r
1961	713.4r	134.9r	29.9	63.9r	942.1r	388.3r	112.8r	116.6r	115.0	1,674.8r
1962	802.9r	144.4r	29.1r	70.3r	1,046.7r	406.1r	114.6r	121.5r	125.0	1,813.9r
1963	900.1r	163.0r	28.1r	73.8r	1,165.0r	453.4r	128.0r	132.7r	135.0	2,014.1r
1964	1,003.7r	182.1r	25.9r	76.8r	1,288.5r	495.7r	137.6r	147.6r	145.0	2,214.4r
1965	1,125.9	210.7	25.9	79.8	1,442.3	545.1	149.1	159.8	155.0	2,451.3

(a) Excludes hospitals of the Government of Canada (Department of National Health and Welfare).
(b) Excludes hospitals of the Department of National Defence 1955-1960.
(c) Sold by retail drugstores only.
(d) Estimates of expenditures for services of private nurses, chiropractors, osteopaths and optometrists; excludes hospital employees.
r Revised since previous publication.

Section 3 - Earnings of Privately Practising Physicians in Canada

More than 98 per cent of the earnings of privately practising physicians and surgeons in Canada were obtained from fees charged for individual items of professional service. As Table 27 shows, average gross earnings in 1965 from fees plus wages and salaries earned incidental to fee practice were $32,799. This figure was 7 per cent higher than in 1964 and 48 per cent above the 1958 figure. The highest average gross earnings in 1965 were reported in Saskatchewan, at $37,474. In Ontario and Alberta they were above the national average. Average gross incomes in the remaining provinces ranged from $32,037 in Manitoba to $25,596 in Prince Edward Island.

Generally, through the eight-year period 1958-65, average gross earnings have been highest in Ontario and the four western provinces.

The net returns to physicians, after deduction of the expenses of professional fee practice, reveal similar geographic patterns, as seen in Table 28. Net earnings for Canada as a whole averaged $22,064 in 1965. The figure was 7.7 per cent higher than in 1964 and 60 per cent above the 1958 figure. The highest provincial average net income from professional practice was reported by Ontario physicians at $24,188 followed by Saskatchewan physicians at $23,530. The lowest average net income was reported in Prince Edward Island.

Section 4 - Number of Physicians in Canada

Excluding the territories, there were about 23,700 active civilian physicians in Canada at December 31, 1965, or one physician for every 833 persons of the population. Table 29 gives the provincial distribution and population ratios for 1965, and shows also the historical trends for Canada since 1901. British Columbia was continuing to have the most favourable provincial ratio of physicians to population, followed by Ontario and Quebec.

TABLE 27 - AVERAGE GROSS PROFESSIONAL EARNINGS[a] OF ACTIVE FEE-PRACTICE PHYSICIANS AND SURGEONS, CANADA BY PROVINCE, 1958 TO 1965

	1958	1959	1960	1961	1962	1963	1964	1965
	$	$	$	$	$	$	$	$
Newfoundland [b]	24,351	24,669	28,583	27,184	24,809	27,903	30,630	31,620
Prince Edward Island	17,809	18,854	20,177	20,001	19,676	23,413	23,157	25,596
Nova Scotia	19,667	21,341	22,802	23,242	23,302	23,455	25,739	27,486
New Brunswick	19,538	18,918	22,523	24,220	23,978	26,376	27,802	29,622
Quebec	18,264	18,721	19,656	22,118	23,418	25,748	26,813	29,010
Ontario	23,415	24,153	25,534	27,206	27,779	30,641	33,201	35,752
Manitoba [c]	25,036	27,567	25,767	29,072	29,003	28,769	29,103	32,037
Saskatchewan	23,511	23,699	27,102	27,103	23,238	35,657	36,484	37,474
Alberta	24,828	25,254	28,032	29,221	31,187	30,912	32,690	35,397
British Columbia	24,909	26,628	28,066	27,867	27,498	27,670	30,510	31,675
Yukon & Northwest Territories [d]	20,555	19,915	19,398	20,083	20,081	22,007	16,495	27,812
Canada	22,103	22,910	24,288	25,862	26,322	28,690	30,586	32,799

(a) Includes incidental wages and salaries.
(b) Excludes physicians employed on a salaried basis under the Cottage Hospital Medical Service and by subsidized voluntary prepayment plans. The estimated number of such excluded physicians in 1965 was 95.
(c) Excludes some physicians employed on a salaried basis in private group-practice. The estimated number of such excluded physicians in 1965 was 57.
(d) Data for the Yukon and Northwest Territories are posted for record only.

TABLE 28 - AVERAGE NET PROFESSIONAL EARNINGS[a] OF ACTIVE FEE-PRACTICE PHYSICIANS AND SURGEONS, CANADA BY PROVINCE, 1958 TO 1965

	1958	1959	1960	1961	1962	1963	1964	1965
	$	$	$	$	$	$	$	$
Newfoundland [b]	16,807	16,776	19,902	18,640	18,042	19,455	21,523	23,028
Prince Edward Island	10,237	11,427	12,589	13,119	15,448	15,777	16,478	17,835
Nova Scotia	12,862	14,820	16,074	16,070	15,925	15,839	17,851	19,146
New Brunswick	12,409	12,372	15,535	16,288	16,418	17,701	19,255	20,251
Quebec	11,136	11,795	12,870	14,454	15,173	16,696	18,534	20,532
Ontario	14,993	15,605	16,754	17,682	18,306	20,492	22,247	24,188
Manitoba [c]	14,151	15,442	16,000	15,829	16,742	18,178	18,720	19,681
Saskatchewan	14,527	15,096	15,955	15,843	14,619	21,625	23,879	23,530
Alberta	14,815	15,941	17,754	17,925	18,612	19,111	21,117	22,681
British Columbia	15,488	16,953	17,600	17,067	17,284	17,464	19,560	20,121
Yukon & Northwest Territories [d]	16,829	16,271	14,908	15,594	16,368	16,480	13,601	15,731
Canada	13,778	14,590	15,735	16,472	16,970	18,688	20,484	22,064

(a) Includes net professional fees after deducting expenses of practice, and wages and salaries incidental to fee practice.
(b) Excludes physicians employed on a salaried basis under the Cottage Hospital Medical Service and by subsidized voluntary prepayment plans. The estimated number of such excluded physicians in 1965 was 95.
(c) Excludes some physicians employed on a salaried basis in private group-practice. The estimated number of such excluded physicians in 1965 was 57.
(d) Data for the Yukon and Northwest Territories are posted for record only.

TABLE 29 - ACTIVE CIVILIAN PHYSICIANS AND POPULATION PER PHYSICIAN, 1901-65, AND BY PROVINCE, 1965

Province	Active civilian physicians, 1965		Year	Active civilian physicians	
	Number	Population per physician		Number	Population per physician
Newfoundland	315	1,590	Census data:		
Prince Edward Is.	90	1,200	1901	5,475	972
Nova Scotia	875	867	1911	7,411	970
New Brunswick	530	1,181	1921	8,706	1,008
Quebec	6,965	820	1931	10,020	1,034
Ontario	8,815	775	1941	10,723	1,072
Manitoba	1,100	872	Register of		
Saskatchewan	990	963	Physicians,		
Alberta	1,570	927	DNH&W:		
British Columbia	2,450	750	1951	14,163	989
			1954	15,651	977
			1959	19,300	906
			1962	21,011	881
Canada (1)	23,700	833	1965	23,700	833

(1) Ten provinces

PART IV - NATIONAL VOLUNTARY HEALTH AND WELFARE ACTIVITIES

A number of national voluntary agencies carry on important work in the provision of health and welfare services, medical research, and education. These agencies, some of which are described below, complement the services of the federal and provincial authorities in many fields, and play a leading role in stimulating public awareness of health and welfare needs and in promoting action to meet them.

The Canadian Welfare Council. - The Council, established in 1920, is a national voluntary association of English-speaking and French-speaking organizations and individual citizens whose aim is the advancement of social welfare in Canada. Member organizations include community funds and councils, other private social agencies, various federal, provincial, and municipal departments, and citizen groups and individuals active in the fields of health, welfare, and recreation. It furnishes information, technical consultation, and field service in the main areas of social welfare and provides a means of co-operative planning and action by public and private agencies.

The policies and programs of the Council are determined by its members under the leadership of a nationally representative board of governors. With professional staff assuming executive functions, the members work together through Divisions of Family and Child Welfare, Public Welfare, Corrections, Community Funds and Councils, and Aging, and through special committees, such as the newly formed Health Aspects of Welfare. Services of the Council include public information and research. The Council publishes periodicals entitled Canadian Welfare, Bien-Être Social Canadien, and The Canadian Journal of Corrections, a directory of Canadian welfare services, pamphlets and bulletins.

The Canadian Diabetic Association. - Formed in 1953 with headquarters in Toronto, the Association has 31 branches established in nine provinces and a French-language affiliate, l'Association du Diabète, in Quebec. The aims of the organization are to promote public education regarding diabetes and the early detection of cases, to teach diabetics self-care, and to conduct research, for example, the Family Tree

Research Program. The branches support various services such as free diet counselling and summer camps for diabetic children and adults, and hold 'model schools' or institutes from time to time in many cities. Day centres have been established in several large cities for diagnosis, treatment and health education.

The Canadian Red Cross Society. - Established in 1896 in Canada, the Society is affiliated with the International Red Cross and has branches in all ten provinces with national headquarters in Toronto. Its objectives, defined in its Charter, are "... in time of peace or war to carry on and assist in work for the improvement of health, the prevention of disease and the mitigation of suffering throughout the world". Thus Red Cross Society activities have been very broad, ranging from national and international disaster relief services to the support of local projects. Today its largest single activity in Canada is the operation of the national, free blood transfusion service that keeps hospitals supplied with blood provided by voluntary donors. The Society also conducts important health services including hospital and nursing outposts, an extensive homemakers service, sickroom supply loan service, and instruction in water safety and home nursing. The Junior Red Cross promotes health education through its schoolroom branches across Canada; it supports a special fund to supply treatment to needy handicapped children in Canada and a fund to promote understanding among school children of different countries.

The Canadian Rehabilitation Council for the Disabled. - This national agency situated in Toronto was formed in 1962 by the merger of the Canadian Council for Crippled Children with the Canadian Foundation for Poliomyelitis and Rehabilitation. To further its object of co-ordinating activities in all areas for the rehabilitation of the disabled, the Council works with other voluntary agencies concerned with specific disease groups or services. Examples are cerebral palsy, haemophilia and cystic fibrosis. It also carries out such functions as consultative services, public education and some research in rehabilitation. In some provinces, these two organizations have also merged to provide treatment, training, and other patient services to disabled persons of all categories. In other provinces, the handicapped-children's societies administer case-finding, restorative, and related services including parent counselling,

camping and recreation; such programs are financed by Easter Seal campaigns. The foundations for the disabled in these provinces, financed by the March of Dimes or community chests, provide similar services to disabled adults with more emphasis upon vocational rehabilitation; they have been very active in the promotion and establishment of sheltered workshops.

The Victorian Order of Nurses. - Since its inception in 1897, the Victorian Order of Nurses has provided a professional home nursing and health counselling service to patients with any type of illness and regardless of their financial status. In all provinces except Prince Edward Island, the association's nurses carry out, under medical direction, bedside nursing, with emphasis upon chronic conditions, and prenatal, postnatal and newborn care. Prenatal classes are conducted by some 50 branches and 23 branches provide part-time occupational health services to small industries. In some provinces they also assist provincial health authorities in tuberculosis and venereal disease programs and conduct child-health clinics. Through some 110 branches, V.O.N. services are available to approximately 50 per cent of Canada's population. A recent trend has been the extension of services to rural and semi-rural areas. The V.O.N. actively participates in some 15 Home Care programs across Canada. The national office is in Ottawa.

The Canadian National Institute for the Blind. - Since 1918 the Canadian National Institute for the Blind has been the national agency providing a complete social welfare service to the blind and prevention services to the visually impaired. The national office, located in Toronto, supports eight regional divisions covering all provinces and 50 local branches serving 25,776 registered blind persons and over 124,974 prevention cases in 1965-66. Through its Eye Service, free to those in need of assistance, the Institute arranges for eye examinations and pays for medical treatment, glasses, and visual aids; it also supports the operation of several Low Vision Aid Clinics and Eye Banks in the main cities. Vocational, recreation, and educational services for the blind are provided at 20 residential and service centres located across the country. Home teachers visit the newly blinded of all ages including pre-school-age children to teach them independence in daily living and

other skills such as Braille, typing, and handicrafts. Placement officers furnish vocational counselling and arrange for training and employment. Where possible the blind are placed in jobs in general industry, in CNIB canteens, or in farming and small businesses; others are employed in the Institute's sheltered workshops. The National Library circulates Braille magazines and books and recordings and supplies a transcription service to students. The Wise Owl Club, sponsored by the Institute, promotes eye safety in industry. The E.A. Baker Foundation supports research and development in blindness prevention.

The Health League of Canada. - The Health League of Canada, first established in 1918 as the National Committee for Combating Venereal Disease, now supports a wide variety of public health education activities to prevent disease and raise health standards. The League co-operates with health departments and other national health organizations in disseminating health information. Its technical divisions are concerned with various aspects of public health such as immunization, child and maternal health, fluoridation of water, industrial health, nutrition, gerontology, and other fields. In co-operation with its affiliates, the League administers its program from the national office in Toronto; certain branch activities for the Province of Quebec are conducted through its Montreal and Quebec offices. Educational efforts include the provision of speakers for meetings, the preparation of radio scripts, health education films, and the publication of the magazine Health and various bulletins. The League sponsors National Health Week and National Immunization Week.

The St. John Ambulance Association. - The Order of the Hospital of St. John of Jerusalem began as a local unit in Montreal in 1884 and was incorporated on a national basis in 1910 with headquarters in Ottawa. The organization, which has established nine Provincial Councils, is composed of two parts -- the St. John Ambulance Association and the St. John Ambulance Brigade. The Association teaches first aid, home nursing, and artificial respiration, and is used extensively by Civil Defence, Armed Forces, workmen's compensation, and industrial personnel, while the Brigade directs an emergency corps of trained personnel. Provincial and local units operate training courses, first aid posts, ambulance

services, and other activities such as ski patrols. The Association has also organized seven Special Centres for training purposes in several federal government agencies and private industries.

The Canadian Tuberculosis Association. - Founded in 1900 to increase treatment facilities for tuberculosis patients, the Association's objective is the control and ultimate eradication of tuberculosis. Recently, it has also extended its interest to other thoracic diseases. With the decline in need for beds for tuberculosis patients, it has also made available its facilities for general rehabilitation and mental health services. The national office in Ottawa and the provincial and local branches in each province co-operate with the public health agencies in promoting adequate programs for prevention, diagnosis, treatment, and rehabilitation. The provincial associations assist in case-finding by means of mass X-ray and tuberculin-testing surveys of specific areas and higher risk groups, and carry out extensive health education work; some associations also participate in follow-up and rehabilitation of patients. Publication of educational materials and periodicals, organization of the annual Christmas Seal campaign, and research are centred in the national office. It also makes its consultant services available to federal and provincial health departments.

The National Cancer Institute of Canada. - The National Cancer Institute, composed of persons representing professional societies and agencies concerned with cancer research and therapy, was founded in 1947 to develop a nationally co-ordinated research and professional education program. The Institute supports cancer research projects at universities, hospitals, and its own research units, maintains the Canadian Tumour Registry, provides research fellowships, and, in co-operation with the Canadian Medical Association and medical schools, promotes the post-graduate training of radiation physicists and professional education on cancer topics. It also provides an important statistical service by assisting treatment centres in designing clinical trials and developing standard data on cancer problems. The Institute receives financial support from federal-provincial grants and from the Canadian Cancer Society.

The Canadian Cancer Society. - Organized in 1938 to co-ordinate voluntary activities and disseminate knowledge in the cancer field, the Canadian Cancer Society operates in all provinces and has its national office in Toronto. Its chief services are a public education program, welfare services such as transportation, home nursing, boarding and nursing home care, sickroom supplies, and dressings to cancer patients, and the promotion of medical research through support of research facilities and fellowships for advanced study. Voluntary subscriptions to the Society provide about 80 per cent of the funds for the Research Units of the National Cancer Institute of Canada. The Society also sponsors clinical research projects in other institutions.

The Canadian Hearing Society. - Organized in 1940 as the National Society of the Deaf and the Hard of Hearing, the Society has offices in Toronto, Ottawa, and London, Ontario. It is concerned with the preservation of hearing, the treatment of deafness, and the provision of rehabilitation services for those with impaired hearing, including war veterans and children. It provides hearing examinations, counselling, vocational guidance, and job placement services for the deaf or hard-of-hearing, and hearing aids to indigent persons. It also works closely with the two Ontario Schools for the Deaf. The Society publishes The Hearing Eye and distributes educational material on request.

The Canadian Mental Health Association. - Since its organization in 1918 as the National Committee for Mental Hygiene, the Association has promoted mental health and the best possible care of the mentally ill. Its program of public education, professional and lay training, consultative services, and research is carried out by the national office in Toronto, and its provincial divisions and community branches. To develop public understanding of mental health principles, the Association sponsors discussion groups and prepares a variety of educational materials for the press, radio, and television and for professional personnel. Services to mental patients have grown rapidly as branches have established information and referral centres, volunteer hospital visiting programs, White Cross social centres, foster-home care, sheltered workshops, and other personal services for patients and their families. Through various studies of mental health problems and the National Mental Health Research Fund,set up in 1957, the

Association has stimulated new approaches to prevention and treatment in this field. A major theme stressed by the Association is the integration of mental health services with the physical and personnel resources of general medical care. The Association sponsors Mental Health Week.

The Canadian Arthritis and Rheumatism Society. - This group was formed in 1948 to help persons suffering from the rheumatic diseases by a program of treatment, research, and education. Through its national office in Toronto, eight provincial divisions, and local branches in most towns, the Society has assisted many hospitals to establish arthritis clinics and several to set up rheumatic disease in-patient units, and it provides a home physiotherapy service in the larger cities covering about one-half of the population. Five of the divisions provide mobile consultation services to patients and doctors in rural areas. In 1966, over 14,000 patients benefited from treatment or consultative services from the Society's professional staff of 150, mostly physiotherapists. The Society also supports clinical and epidemiological research projects and sponsors the regular Canadian Conference on Research in Rheumatic Diseases. Other activities include public educational services stressing early diagnosis and treatment, and the professional training of rheumatologists.

The Canadian Heart Foundation. - The Canadian Heart Foundation was formed in 1947 by physicians to co-ordinate research and disseminate information. Its membership consists of lay and medical individuals and organizations interested in promoting cardiovascular research and in both public and professional education. The Foundation makes available grants-in-aid to support various medical research projects and fellowship awards to promising scientists in co-operation with the medical schools and teaching hospitals. Its projects are financed by voluntary donations to the Canadian Health Fund as well as by federal and provincial grants. The Foundation is a federation of six provincial Heart Foundations and a Maritime Division. The national office is in Toronto.

The Canadian Paraplegic Association. - The Association was formed in 1945 by a group of paraplegic veterans to ensure provision of adequate treatment and rehabilitation

facilities for all persons suffering paralysis caused by disease or injury. Through its national office in Toronto and seven divisional and local offices, the Association's rehabilitation program makes available physical restoration, counselling, and vocational services, prosthetic appliances, and personal aids and other activities to promote the social well-being of paraplegics. The Association also conducts some research. A comprehensive service is provided at Lyndhurst Lodge Retraining Centre in Toronto, owned by the Association; elsewhere it arranges for these services with various hospitals and other rehabilitation agencies.

The Multiple Sclerosis Society of Canada. - The Society has been organized since 1948 to support research in multiple sclerosis and allied diseases and to educate the public on the social problem of multiple sclerosis. Its 31 local chapters located in ten provinces raise funds mainly for research but they also provide welfare services to patients, such as friendly visiting, wheel chairs and other personal aids. There is one provincial division in Ontario and the national office has been moved to Toronto. Grants for its medical research projects and fellowships are administered from the national office now in Toronto. Some local chapters have undertaken patient registries. In an effort to improve patient services several Ladies' Associations for Multiple Sclerosis (LAMS) groups have been organized in a few branches.

The Canadian Association for Retarded Children. - The Association was incorporated in 1958 to co-ordinate the work of organizations for the mentally retarded, now represented by ten provincial and over 300 local groups. Membership of the local groups exceeds 20,000 most of whom are parents of mentally retarded children. The Association promotes the establishment of assessment clinics, day-training classes, sheltered workshops and activity centres, summer camps, and recreational programs; it also supports research and demonstration projects. The Association is extensively engaged in the operation of special classes and sheltered workshops for trainable retarded children and adults. Financial support comes from local fund-raising campaigns, community chests, and, in varying degrees, from provincial education and other departments. The national office is in Toronto.

The Muscular Dystrophy Association of Canada. - This Association was organized in 1954 to stimulate and unify research efforts into the cause, nature, and treatment of muscular dystrophy and related diseases and to promote the establishment of facilities for diagnostic, consultative, and treatment services. Under the direction of a national office in Toronto supported by 33 local chapters, its chief activity is the sponsoring of basic and applied research projects in medical schools and other centres across the country. Other activities include providing appliances and transportation to muscular dystrophy patients and supplying information to the public and professionals.

The Canadian Cystic Fibrosis Foundation. - This recently organized national agency has 19 affiliated chapters located in seven provinces. Its objects are to aid patients with this inherited condition, and to promote research, professional training, and public understanding. Several chapters have established clinics for the diagnosis and treatment of cystic fibrosis among children, and all provide patient services including special drugs and equipment. The Foundation initiated its research program in 1962, and intensified the distribution of educational material to parents and the general public. The national office is in Toronto.

Voluntary Medical Insurance. - About 12,010,000 Canadians, or 61 per cent of the population of Canada, had voluntarily secured some protection against the costs of physicians' services at the end of 1965. This protection was provided by some 60 nonprofit plans with an enrolment of 6,530,000 and 80 private companies giving coverage to an estimated 5,480,000 persons. The total was 5,780,000 above the 1955 figure, which represented only 40 per cent of the population.

The nonprofit plans took in about $216,800,000 in premiums and $5,150,000 in other revenue in 1965, paid out $188,900,000 in benefits and $14,500,000 for administration, and were left with a surplus of approximately $18,550,000. Thus, for every dollar of premiums, 87 cents were paid out in benefits, which amounted to approximately $28.93 per person covered. In 1955 benefit payments had been $41,400,000, representing 89 cents of the premium dollar and amounting to only $13.17 per person.

Profit-making private companies wrote $146,200,000 of premiums for health protection in 1965; they paid out $113,300,000 in claims.

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